

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0995738

Reg. Dist. No.

9985

|  |  |   |                                 |  |  |   |  |
|--|--|---|---------------------------------|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Balto.</u> <span style="float: right;">MARYLAND</span>  |  |   |                                 | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>                                |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Riderwood</u>   |  |   | c. LENGTH OF STAY IN 1b<br><br> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Riderwood</u> |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>1603 Essex Farm Rd.</u>   |  |   |                                 | d. STREET ADDRESS<br><u>1603 Essex Farm Rd.</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) First Middle Last<br><u>JOHN F. ACKERMAN</u>   |  |   |                                 | <b>4. DATE OF DEATH</b><br>Month Day Year<br><u>Oct. 30 19 56</u>  |  |   |  |
| 5. SEX<br><u>male</u>  |  | 6. COLOR OR RACE<br><u>white</u>  |                                 | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                |  | 8. DATE OF BIRTH<br><u>Jan. 19, 1907</u>  |  |
| 9. AGE (In years last birthday)<br><u>49</u> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                 | IF UNDER 24 HRS.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>General Agent</u> |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Insurance</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Md.</u>   |                                 | 12. CITIZEN OF WHAT COUNTRY?<br><br>   |  |   |  |
| 13. FATHER'S NAME<br><u>Wm. F. Ackerman</u>  |  |   |                                 | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth Allen Crouse</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>no</u>  |  | 16. SOCIAL SECURITY NO.<br><u>273-05-7150</u>   |                                 | 17. INFORMANT<br>Address <u>Riderwood</u><br><u>Mrs. Annie E. Ackerman-1603 Essex Farm Rd.</u>   |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Insufficiency</u><br>DUE TO (c) <u>2 yrs</u><br>INTERVAL BETWEEN ONSET AND DEATH  |  |   |                                 |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |                                 |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |                                 |  |  |   |  |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>   |  |   |                                 | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |   |  |
| EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>   |  |   |                                 | DATE SIGNED <u>10/31/56</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>11/2/56</u>   |                                 | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Meadowridge Mem. Pk.</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Elkridge, Md.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Chas. J. Lickner &amp; Sons - Balto</u>   |  |   |                                 | ADDRESS<br><u>17</u>   |  | 24a. RECEIVED BY REGISTRAR<br>DATE <u>Nov. 5, 1956</u>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>Walter Gray</u>   |  |   |                                 | <br>   |  |   |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the Registrar for a burial, cremation, or removal.

STANDARD STATE DEPARTMENT - HEALTH - PAGE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 7 1956

RECEIVED

09959<sub>38</sub>

|   |                           |   |                                       |
|---|---------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/><br>a. STATE <b>N.C.</b> b. COUNTY     |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>55 TOWSON</b>  |                           | c. LENGTH OF STAY IN 1b<br><b>1 WK.</b>   |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>712 MURDOCK RD.</b>  |                           | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WILMINGTON 70 x 3</b>  |                                       |
| 3. NAME OF DECEASED (Type or print) <b>ANNA C. MRS. AINSWORTH</b>   |                           | 4. DATE OF DEATH <b>OCT. 20 1956</b>  |                                       |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        | 8. DATE OF BIRTH <b>AUG. 18, 1910</b> |
| 9. AGE (In years last birthday) <b>46 yrs.</b>  |                           | 10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>  |                                       |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE</b>  |                           | 12. KIND OF BUSINESS OR INDUSTRY <b>—</b>   |                                       |
| 13. BIRTHPLACE (State or foreign country)<br><b>MD.</b>   |                           | 14. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                       |
| 15. FATHER'S NAME<br><b>HENRY F. DAHLMER</b>  |                           | 16. MOTHER'S MAIDEN NAME<br><b>DEMME</b>  |                                       |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |                           | 18. SOCIAL SECURITY NO. <b>215-09-2475</b>  |                                       |
| 19. INFORMANT <b>Mr. Harry Ainsworth - 140 Lake Forest Pkwy.</b>  |                           | Address <b>Wilmington, N. C.</b>  |                                       |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                           |   |                                       |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b>  |                           | INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 HRS</b>   |                                       |
| DUE TO <b>420.1</b>   |                           |   |                                       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>  |                           | <b>30 YRS</b>   |                                       |
| (c)   |                           |   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>OBESITY</b>  |                           |   |                                       |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |   |                                       |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                           |   |                                       |
| ACTUAL SIGNATURE <b>William A. Pillsbury</b>  |                           | DATE SIGNED <b>10/20/56</b>   |                                       |
| EXAMINER'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>  |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                           | 22b. DATE THEREOF <b>10/23/56</b>   |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>  |                           | 22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Thm. J. Dickner &amp; Sons - Balto. 17 Md</b>   |                           | 24a. REC'D BY REGISTRAR <b>DATE Oct. 22, 1956</b>   |                                       |
|   |                           | 24b. REGISTRAR'S SIGNATURE <b>Malcolm Gray</b>  |                                       |

MEDICAL CERTIFICATION

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be submitted within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

RECEIVED  
BUREAU V. S.  
OCT 23 1956



## CERTIFICATE OF DEATH

Reg. Dist. No. 38

9987

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9802 Hilltop Drive</u>   |  |  |  | d. STREET ADDRESS <u>9802 Hilltop Drive</u>  |  |   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Mr. Thomas Alder</u>  |  |  |  | 4. DATE OF DEATH <u>October 30th 1956</u>  |  |   |  |
| 5. SEX <u>male</u>   |  | 6. COLOR OR RACE <u>white</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Apr. 8, 1864</u>  |  |
| 9. AGE (In years last birthday) <u>92</u> yrs.   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Fireman, B &amp; O R R</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>   |  |
| 13. FATHER'S NAME <u>John Alder</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Mary Turnbull</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT <u>Mrs. Gertrude Jenkins, 9802 Hilltop Dr.</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-vascular renal disease</u><br><u>442x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u> |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>Sept. 20, 1956</u> to <u>Oct. 30, 1956</u> that I last saw the deceased alive on <u>Sept. 20, 1956</u> , and that death occurred at <u>5:30 M.</u> from the causes and on the date stated above.  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>G. M. Bacon</u> M.D. <u>2810 Taylor Ave</u>  |  |  |  | DATE SIGNED <u>NOV - 1 1956</u>  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>A. M. BACON</u>   |  |  |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>10/2/56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>         |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>   |  |  |  | 24a. REC'D BY REGISTRAR <u>NOV - 1 1956</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>                                   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU Y. S.

NOV 1 1956

RECEIVED

37

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 15 1956

RECEIVED

1

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 9989 CERTIFICATE OF DEATH

09961

Reg. Dist. No. 33

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH   |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED   |  |   |  |
| COUNTY <b>BALTIMORE</b>   |  | STATE <b>LOUISIANA</b> <del>MISSISSIPPI</del> <b>PARRISH OF ORLEANS</b>          |  | CITY (If outside corporate limits, write RURAL and give nearest town)                 |  | CITY (If outside corporate limits, write RURAL and give nearest town) |  |
| CITY OR TOWN <b>PIKESVILLE</b>  |  | LENGTH OF STAY (in this place) <b>6 weeks</b>                                    |  | CITY OR TOWN <b>NEW ORLEANS</b>   |  | CITY OR TOWN <b>NEW ORLEANS</b>                                       |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>706 SUDBROOK ROAD, 8,</b>  |  |  |  | STREET ADDRESS (If rural give location)   |  |   |  |
| 3. NAME OF DECEASED (Type or Print) <b>RUTH DUFFY BARR</b>  |  |  |  | 4. DATE OF DEATH <b>October 17, 1956</b>  |  |   |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>WHITE</b>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>                       |  | 8. DATE OF BIRTH <b>August 26, 1892</b>                               |  |
| 9. AGE last birthday <b>64</b> yrs.   |  | 10. IF UNDER 1 YEAR  |  | 11. IF UNDER 24 HRS.  |  | 12. IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>New Orleans, Louisiana</b>               |  | 12. CITIZEN OF WHAT COUNTRY? <b>United States</b>                     |  |
| 13. FATHER'S NAME <b>Andrew J. Duffy</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Lucy B. Duffy</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT & ADDRESS <b>Pikesville, 8, Md. David N. Barr, Jr. 706 Sudbrook Rd.</b> |  |   |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |  |  | 18. MEDICAL CERTIFICATION   |  |   |  |
| 151X IMMEDIATE CAUSE (A) <b>CARCINOMATOSIS, extension into lungs</b>  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>                                      |  |   |  |
| ANTECEDENT CAUSE(S) DUE TO <b>Carcinoma of the stomach with metastasis</b>  |  |  |  | 2 months  |  |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)  |  |  |  |   |  |   |  |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION <b>August 2, 1956</b>  |  | 19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of the stomach with metastasis</b> |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)           |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                          |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 21e. INJURY OCCURRED   |  | 21f. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>Sept. 15, 1956</b> , to <b>October 17, 1956</b> , that I last saw the deceased alive on <b>October 17, 1956</b> , and that death occurred at <b>9:00 P.M.</b> from the causes and on the date stated above. |  |  |  |   |  |   |  |
| SIGNATURE <b>Mildred T. Tralada</b>   |  | DATE THEREOF <b>Oct 22, 1956</b>   |  | NAME OF CEMETERY OR CREMATORY <b>New Orleans</b>                                      |  | LOCATION (City, town, or county) (State) <b>Louisiana</b>             |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | DATE THEREOF <b>Oct 22, 1956</b>   |  | NAME OF CEMETERY OR CREMATORY <b>New Orleans</b>                                      |  | LOCATION (City, town, or county) (State) <b>Louisiana</b>             |  |
| 24. REC'D BY REGISTRAR <b>10-19-56</b>  |  | REGISTRAR'S SIGNATURE <b>Mary B. Elue</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Berryman &amp; Sons</b>                       |  | ADDRESS <b>Pikesville, Md.</b>  |  |



# CERTIFICATE OF DEATH

|                                       |  |                                       |  |
|---------------------------------------|--|---------------------------------------|--|
| Name of Deceased<br>[Illegible]       |  | Sex<br>[Illegible]                    |  |
| Date of Birth<br>[Illegible]          |  | Place of Birth<br>[Illegible]         |  |
| Date of Death<br>[Illegible]          |  | Place of Death<br>[Illegible]         |  |
| Cause of Death<br>[Illegible]         |  | Manner of Death<br>[Illegible]        |  |
| Signature of Physician<br>[Illegible] |  | Signature of Registrar<br>[Illegible] |  |

BUREAU V. 2

OCT 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9990

CERTIFICATE OF DEATH

099624

Reg. Dist. No.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY                                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>  |  |   |  | c. LENGTH OF STAY IN lb<br><b>19 Days</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Veterans Administration Hospital</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ALBERT</b> Middle <b>C.</b> Last <b>BATTY</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>5</b> Year <b>1956</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Colored</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>September 12, 1891</b>                               |  |
| 9. AGE (In years last birthday) <b>65</b> yrs.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Janitor</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Office Building</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Richmond, Virginia</b>      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 13. FATHER'S NAME<br><b>Charles Batty</b>   |  |   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Besty MN: Unknown</b>  |  |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>                           |  |   |  |
| 16. SOCIAL SECURITY NO<br><b>216-03-8584</b>  |  |   |  | 17. INFORMANT Address<br><b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE SIGMOID WITH METASTASIS TO THE LIVER</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b>   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |   |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>a. p.</b> <b>19</b> p. m. <b>VA</b>   |  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>September 16, 1956</b> , to <b>October 5, 1956</b> , and that death occurred at <b>5:37 A.M.</b> , from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Donald D. Mark</b>  |  |   |  | ADDRESS (Street, city or town, state)<br><b>M.D. VAH, FORT HOWARD, MARYLAND</b>   |  | DATE SIGNED<br><b>10/5/56</b>   |  |
| PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M.D.</b>   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>10-8-56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles R. Law</b>   |  |   |  | ADDRESS<br><b>Charles R. Law Mortuary, 802-04 Madison Ave.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE   |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Dawson L. Larkin</b>   |  |   |  |

BUREAU V. 8

OCT 9 1956

RECEIVED

9991

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

|   |  |                                      |  |   |  |   |  |
|---|--|--------------------------------------|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  |                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY                              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>  |  |                                      |  | c. LENGTH OF STAY IN 1b<br><b>3 hrs 45 mins</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Veterans Administration Hospital</b>   |  |                                      |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |  |   |  |
|   |  |                                      |  | d. STREET ADDRESS<br><b>3665 Chestnut Avenue</b>  |  |   |  |
|   |  |                                      |  | • IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>THOMAS</b> Middle <b>C</b> Last <b>BAUBLITZ</b>   |  |                                      |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>14</b> Year <b>1956</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>     |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3/14/1900</b>  |  |
|   |  |                                      |  | 9. AGE (In years last birthday)<br><b>56</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min                                |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Sewing Machine Adjuster</b>   |  |                                      |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Sewing Machine Mfg. Maryland (Carroll Co.)</b>  |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>  |  |                                      |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>Charles Baublitz</b>  |  |                                      |  | 14. MOTHER'S MAIDEN NAME<br><b>Alice Eberg</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes WWII</b>  |  |                                      |  | 16. SOCIAL SECURITY NO.<br><b>214-14-6093</b>   |  |   |  |
| 17. INFORMANT<br><b>Clin. Rec. Vets. Admin. Hosp. Ft. Howard, Md.</b>   |  |                                      |  | Address   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br>DUE TO <b>CORONARY THROMBOSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>(c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WEEK</b>   |  |                                      |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Arteriosclerosis, generalized</b>   |  |                                      |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                      |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                      |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>   |  |                                      |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |                                      |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <b>October 14, 1956</b> to <b>October 14, 1956</b> and that death occurred at <b>8:05 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE <b>C. J. Papastrat, M.D.</b> M.D. <b>Veterans Administration Hospital 10/15/56</b><br>PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M.D.</b> <b>Fort Howard, Maryland</b> |  |                                      |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>10-18-56</b> |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Paul E. Chmowicz Jr.</b><br><b>Chmowicz Funeral Home 3615 Chestnut Ave., Balto</b>   |  |                                      |  | 24a. REC'D BY REGISTRAR<br><b>DATE 11/1/56</b>  |  |   |  |
|   |  |                                      |  | 24b. REGISTRAR'S SIGNATURE<br><b>Lawson L. Garber</b>   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

be returned by the hospital or attending physician.

GENERAL INSTRUCTIONS: After this certificate has been signed by the attending physician and completed, it should be filed with the Registrar. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 1961

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9992

## CERTIFICATE OF DEATH

09964

Reg. Dist. No.

|   |                                  |   |  |   |   |   |  |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lutherville, Md.</b>   |                                  |   |  | c. LENGTH OF STAY IN 1b<br><b>Life</b>  |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>Walter</b> Last <b>Bell</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>10</b> Year <b>1956</b>   |   |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 27, 1888</b> | 9. AGE (In years last birthday)<br><b>68</b> yrs.   | 10. IF UNDER 1 YEAR<br>Months <b>14</b> Days <b>01</b> Hours <b>00</b> Min. | 11. IF UNDER 24 HRS<br>Hours <b>00</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Self Employed</b>   |                                  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Fire Extinguisher Md</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>John F. Bell</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Laura Phillips.</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Address<br><b>Maggie Bell, 1400 Railroad Ave.</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>coronary thrombosis</b><br>(c) <b>arteriosclerotic cardiovascular disease</b>                       |                                  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>14 hours</b><br><b>2 years</b>               |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>October 10, 1956</b> to <b>October 10, 1956</b> , that I last saw the deceased alive on <b>October 10, 1956</b> , and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>11155 F. 11, 1155 F. Lutherville, Maryland</b> DATE SIGNED <b>10-11-1956</b> |                                  |   |  |   |   |   |  |
| ACTUAL SIGNATURE <b>[Signature]</b>   |                                  |   |  | M.D. <b>202 Woodrow Wilson Ave. Lutherville, Maryland</b>   |   |   |  |
| PHYSICIAN'S NAME (Type)   |                                  |   |  |   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Oct 13/56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Saters</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Balto Co., Md</b>               |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Austin E. Donovan - 3818 Roland Ave.</b>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>10-15-1956</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be relayed by the hospital or attending physician. The funeral director: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the registrar.

RECEIVED

OCT 1 - 1956

BUREAU V. 3

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9971 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09965

Reg. Dist. No.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>DUNDALK</b>  |   | c. LENGTH OF STAY IN 1b<br><b>37 YRS</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>61 AVALON AVE</b>  |   | e. STREET ADDRESS<br><b>61 AVALON AVE</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>A.</b> Last <b>BENSON</b>  |   | 4. DATE OF DEATH<br>Month <b>OCT</b> Day <b>5</b> Year <b>1956</b>  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JUNE 30-1900</b>                            |
| 9. AGE (In years last birthday)<br><b>56 yrs.</b>   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min.                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CHECKER</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SHIP YARD</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>OHIO</b>           |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>D. S. A</b>  |   | 13. FATHER'S NAME<br><b>BENSON</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>ANNE</b>   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |  |
| 16. SOCIAL SECURITY NO.<br><b>213-076007</b>  |   | 17. INFORMANT<br><b>MRS HAZEL BENSON</b> Address <b>3541 MERIDIAN INDIANAPOLIS</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b)<br>DUE TO (c)  |   |   | INTERVAL BETWEEN ONSET AND DEATH                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Am</b>   |  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                               |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |   |   |  |
| ACTUAL SIGNATURE<br><b>M B Davis MD</b>   |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type)<br><b>M B. DAVIS MD</b>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
|   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 22b. DATE THEREOF<br><b>OCT 9 1956</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>COLGATE MD</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>ULLRICH FUNERAL HOME</b>   |   | 24a. REC'D BY REGISTRAR<br><b>DATE 10 15 56</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Thom Kelly</b>                    |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. Your files should be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

BUREAU V. S.

OCT 10 1900

RECEIVED

9993

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Putty Hill</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Putty Hill</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10041 Harford Rd.</u>   |  | d. STREET ADDRESS <u>10041 Harford Rd.</u>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Johanna D. Blacklock</u>   |  | 4. DATE OF DEATH <u>October 22, 1956</u>   |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 23, 1873</u>  |
| 9. AGE (In years last birthday) <u>83</u> yrs   |  | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |  |
| 13. FATHER'S NAME <u>William Gerke</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Louise Cruse</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <u>None</u>  |  |
| 17. INFORMANT <u>Joseph A. Blacklock</u>  |  | Address <u>1600 Walterswood Rd.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sclerosis Coronary</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis generalized</u><br>DUE TO<br>(c) <u>  </u> |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <u>  </u> p. m. <u>  </u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>For about 12 years</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>Oct. 22, 1956</u> , and that death occurred on <u>  </u> , from the causes and on the date stated above.  |  |  |  |
| ACTUAL SIGNATURE <u>Louise M. Reelin</u> M.D.   |  | ADDRESS (Street, city or town, state) <u>5901 Ayloshure Road Baltimore 12, Md.</u>   |  |
| PHYSICIAN'S NAME (Type) <u>Baltimore 12, Md.</u>  |  | DATE SIGNED  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>Oct. 24, 1956</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Chapel</u>   | 22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>  |  | ADDRESS <u>7401 Belair Rd.</u>   |  |
| 24a. REC'D BY REGISTRAR <u>CT</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>J. M. Deacon</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU A. B.

OCT 25 1906

RECEIVED

9994

## CERTIFICATE OF DEATH

Reg. Dist. No.

34

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY                                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6424 Liberty Road</u>  |   | d. STREET ADDRESS <u>6424 Liberty Road</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>JOSEPH</u> <u>BLASS</u>  |   | 4. DATE OF DEATH<br>Month <u>10-</u> Day <u>13-</u> Year <u>1956</u>   |   |
| 5. SEX <u>male</u>   | 6. COLOR OR RACE <u>white</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-1-1895</u>              |
| 9. AGE (In years last birthday) <u>61</u> yrs.   |   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Russia</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>Wolf</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Bashera</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT <u>Sarah Blass - same</u>  |   | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>7 mo</u> |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)          |
| 21. I certify that I attended the deceased from <u>2 Apr</u> , 19 <u>54</u> , to <u>13 Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11 Oct</u> , 19 <u>56</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.   |   |  |   |
| ACTUAL SIGNATURE <u>M. J. Van</u>  |   | ADDRESS (Street, city or town, state) <u>3601 Patterson Ave</u>  |   |
| PHYSICIAN'S NAME (Type) <u>Baltimore 7, Md</u>   |   | DATE SIGNED <u>10/14/56</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF   | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u>  | <u>10-15-1956</u>   | <u>WASHINGTON RD</u>   | <u>BALTO. MD</u>                              |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>   |   | ADDRESS <u>2100 Eutaw Place</u>  |   |
| 24a. REC'D BY REGISTRAR <u>51</u>  |   | 24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

16 1956

RECEIVED

1

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09968

## 9995 CERTIFICATE OF DEATH

Reg. Dist. No. ....

|  |                           |  |                                       |   |                 |  |                  |
|--|---------------------------|--|---------------------------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH  |                           |  |                                       | 2. USUAL RESIDENCE (HOME) OF DECEASED   |                 |  |                  |
| COUNTY <u>Iti or</u>   |                           | MARYLAND   |                                       | STATE <u>1</u>  |                 | COUNTY <u>10</u>                                       |                  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>tonsville</u>   |                           | LENGTH OF STAY (In this place)   |                                       | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Catonville</u> |                 |  |                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Hol st Ave.</u>  |                           |  |                                       | STREET ADDRESS (If rural give location)<br><u>16 Hol ehurst Ave.</u>                            |                 |  |                  |
| 3. NAME OF DECEASED (Type or Print)  |                           |  |                                       | 4. DATE OF DEATH  |                 |  |                  |
| (First) <u>Herbert</u>   |                           | (Middle) <u>3.</u>   |                                       | (Last) <u>Bohanan</u>   |                 | (Month) (Day) (Year)<br><u>Oct. 2 1950</u>             |                  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>        | 8. DATE OF BIRTH <u>April 7, 1879</u> | 9. AGE last birthday <u>77</u> yrs.   | IF UNDER 1 YEAR |  | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prop. Ret.</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>                       |                                       | 11. BIRTHPLACE (State or foreign country)   |                 | 12. CITIZEN OF WHAT COUNTRY?                           |                  |
| 13. FATHER'S NAME <u>Charles M. Bohanan</u>  |                           |  |                                       | 14. MOTHER'S MAIDEN NAME <u>Laura Fur 1</u>   |                 |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)  |                           | 16. SOCIAL SECURITY NO.  |                                       | 17. INFORMANT & ADDRESS <u>Rev. J. M. Bohanan 16 Hol ehurst</u>                                 |                 |  |                  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                           |  |                                       | 18. MEDICAL CERTIFICATION   |                 | INTERVAL BETWEEN ONSET AND DEATH                       |                  |
| IMMEDIATE CAUSE (A)  |                           |  |                                       | <u>Coronary Embolism</u>  |                 | <u>1 hr.</u>   |                  |
| ANTECEDENT CAUSE(S) DUE TO   |                           |  |                                       | <u>Cardio-Vascular Renal Disease</u>  |                 | <u>7 yrs</u>   |                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)   |                           |  |                                       | <u>Emphysema</u>  |                 | <u>6 mo.</u>   |                  |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                           |  |                                       |   |                 |  |                  |
| 19a. DATE OF OPERATION   |                           | 19b. MAJOR FINDINGS OF OPERATION                                       |                                       | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                           |                 |  |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) |                                       | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                    |                 |  |                  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>  |                           | 21e. INJURY OCCURRED   |                                       | 21f. HOW DID INJURY OCCUR?  |                 |  |                  |
| 22. I hereby certify that I attended the deceased from <u>8:18</u> , 19 <u>49</u> , to <u>10:12</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>10/1</u> , 19 <u>50</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above. |                           |  |                                       |   |                 |  |                  |
| SIGNATURE <u>George E. Kistner M.D.</u>  |                           |  |                                       | ADDRESS (Street, city, town, state) <u>805 3rd Ave Catonville Md</u> DATE SIGNED <u>10.2.50</u> |                 |  |                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |                           | DATE THEREOF <u>10-5-50</u>  |                                       | NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>   |                 | LOCATION (City, town, or county) (State) <u>Calico</u> |                  |
| 24. REC'D BY REGISTRAR <u>1010 1456</u>  |                           | REGISTRAR'S SIGNATURE  |                                       | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Funeral Home Catonville Md</u>                      |                 | ADDRESS  |                  |
| DATE   |                           |  |                                       |   |                 |  |                  |

BUREAU V. B.

JUL 9 1956

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No.

44

9996

|  |                                 |  |                                  |   |   |  |  |
|--|---------------------------------|--|----------------------------------|---|---|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                 |  |                                  | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision)<br>a. STATE <b>Maryland</b> b. COUNTY |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>  |                                 |  |                                  | c. LENGTH OF STAY IN lb <b>8 Days</b>   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>   |                                 |  |                                  | d. STREET ADDRESS <b>127 Fleming Drive</b>  |   |  |  |
| 3. NAME OF DECEASED (Type or print) <b>BERNARD C BOOKER</b>  |                                 |  |                                  | 4. DATE OF DEATH <b>October 14 1956</b>   |   |  |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>Colored</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>12/11/23</b> | 9. AGE (In years last birthday) <b>32</b> yrs.  | IF UNDER 1 YEAR: Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min. | IF UNDER 24 HRS  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>   |                                 |  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>  |   | 11. BIRTHPLACE (State or foreign country) <b>Sparrows Point, Md.</b>     |  |
| 13. FATHER'S NAME <b>Henry Whitley Booker</b>  |                                 |  |                                  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   |  |  |
| 14. MOTHER'S MAIDEN NAME <b>Theresa Booker</b>   |                                 |  |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW-II</b>                                       |   |  |  |
| 16. SOCIAL SECURITY NO. <b>220 14 1122</b>   |                                 |  |                                  | 17. INFORMANT <b>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</b>   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MALIGNANT HYPERTENSION</b><br><b>4445X</b> DUE TO <b>NEPHROSCLEROSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |                                 |  |                                  |   |   |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 |  |                                  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 |  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                              |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year <b>19</b><br>Hour a. p. <b>19</b> p. m.   |                                 |  |                                  | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>                    |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town) _____ (County) _____ (State) _____   |                                 |  |                                  | 20g. (City or town) _____ (County) _____ (State) _____  |   |  |  |
| 21. I certify that I attended the deceased from <b>October 6, 1956</b> , to <b>October 14, 1956</b> , that I last saw the deceased on <b>October 14, 1956</b> , and that death occurred at <b>2:00 A.M.</b> , from the causes and on the date stated above.  |                                 |  |                                  |   |   |  |  |
| ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Maryland</b>  |                                 |  |                                  |   |   |  |  |
| ACTUAL SIGNATURE <b>C.M. Snyder M.D.</b>   |                                 |  |                                  | M.D. <b>VAH, Fort Howard, Maryland</b> <b>10/14/56</b>  |   |  |  |
| PHYSICIAN'S NAME (Type) <b>C.M. SNYDER, M.D.</b>   |                                 |  |                                  | ADDRESS <b>VAH, Fort Howard, Maryland</b>   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                                 | 22b. DATE THEREOF <b>10/18/56</b>  |                                  | 22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>  |   | 22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>   |                                 |  |                                  | ADDRESS <b>802-04 Madison Ave. Baltimore, Md.</b>   |   | 24a. REC'D BY REGISTRAR <b>16 1956</b>                                   |  |
| 24b. REGISTRAR'S SIGNATURE <b>James L. Farley</b>  |                                 |  |                                  |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1956

NEW YORK

9997

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

|   |                                     |  |   |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Villa Nova</b>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Robb Nursing Home</b>  |                                     | d. STREET ADDRESS<br><b>4015 Villa Nova Road</b>   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>ELIA D. BORNHANN</b>  |                                     | 4. DATE OF DEATH Month Day Year<br><b>10 6 19 56</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b> | 8. DATE OF BIRTH<br><b>3/11/1869</b>  |
| 9. AGE (In years last birthday) yrs<br><b>87</b>  |                                     | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>William Hooper</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>?</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                     | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| 17. INFORMANT<br><b>Mrs. Virginia Warnsmann</b>   |                                     | Address<br><b>4015 Villa Nova Road</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>to IX</b> DUE TO <b>Gastric intestinal hemorrhage</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Aneurysm</b> (c) <b>?</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio sclerosis generalized</b> |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>7</b>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>— 19</b>  |                                     | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>           |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>fall</b> 19 <b>50</b> , to <b>Oct 6</b> 19 <b>56</b> , that I last saw the deceased alive on <b>Oct 5</b> 19 <b>56</b> , and that death occurred at <b>—</b> M., from the causes and on the date stated above.   |                                     |  |   |
| ACTUAL SIGNATURE<br><b>Louis Dalman</b>   |                                     | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Pikesville 8/11/56</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>Louis DALMAN</b>  |                                     |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>10/8/56</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. James Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>My Lady's Manor, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Tucker &amp; Sons - North Baltimore</b>   |                                     | 24a. REC'D BY REGISTRAR<br><b>DATE</b>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Michael Gray</b>   |                                     |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

7CT 9 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>  |  | c. LENGTH OF STAY IN 1b <u>Transient</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Putty Hill Rd.</u>   |  | d. STREET ADDRESS <u>Sparks</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |   |
| 3. NAME OF DECEASED (Type or print) <u>COURTNEY Oliver Rowman</u>  |  | 4. DATE OF DEATH <u>October 10 1956</u>  |   |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-11-1904</u>                  |
| 9. AGE (in years last birthday) <u>51</u> yrs.   |  | IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>haboee</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Metropolitan Dis. Balto. County</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>Wm. T. Rowman</u>   |  | 14. MOTHER'S MAIDEN NAME <u>? Lawson</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |  | 16. SOCIAL SECURITY NO. <u>215-16-1879</u>   |   |
| 17. INFORMANT <u>Ada V. Rowman</u>   |  | Address <u>Phoenix, Md.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>DUE TO <u>Advanced Generalized Atherosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>under</u><br>DUE TO (c)  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>2-3 minutes</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |  |   |
| ACTUAL SIGNATURE <u>John C. Hyle</u>   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
|  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>10-13-56</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Matt Brooks</u>   |  | 24a. REC'D BY REGISTRAR <u>DATE: 10/13/56</u>  |   |
|  |  | 24b. REGISTRAR'S SIGNATURE <u>J. H. Hyle</u>   |   |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, marking the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

BUREAU V. S.

RECEIVED  
JUN 5 1954

1

INSTRUCTIONS

24 hours after death. The law requires that the death certificate be filed with the registrar within 10 days after death. After this certificate has been executed by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9999

## CERTIFICATE OF DEATH

09972

32

Reg. Dist. No. ....

|   |                                |  |                                       |
|---|--------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH   |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED                                  |                                       |
| COUNTY <u>Albany</u>  | STATE <u>MARYLAND</u>          | CITY <u>Stevenson</u>  | COUNTY <u>Albany</u>                  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  | LENGTH OF STAY (In this place) | CITY (If outside corporate limits, write RURAL and give nearest town)  |                                       |
| TOWN <u>Stevenson</u>   |                                | TOWN <u>Stevenson</u>  |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Julie</u>  |                                | STREET ADDRESS (If rural give location) <u>Villa Julie Valley</u>      |                                       |
| 3. NAME OF DECEASED (Type or Print) <u>Sister Paulina (Elizabeth Brady)</u>   |                                | 4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 15 1956</u>              |                                       |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>        | 8. DATE OF BIRTH <u>Nov. 12, 1872</u> |
| 9. AGE last birthday <u>77</u> yrs.   |                                | 10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)                     |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>  |                                | 10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>                     |                                       |
| 11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>   |                                | 12. CITIZEN OF WHAT COUNTRY?   |                                       |
| 13. FATHER'S NAME <u>Thomas Brady</u>   |                                | 14. MOTHER'S MAIDEN NAME <u>Bebiana Vale</u>                           |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>--</u>   |                                | 16. SOCIAL SECURITY NO. <u>--</u>                                      |                                       |
| 17. INFORMANT & ADDRESS <u>Sister Marie Coloma Villa</u>  |                                |  |                                       |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                | 18. MEDICAL CERTIFICATION  |                                       |
| IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>   |                                | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>                         |                                       |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiac vascular disease</u>   |                                | <u>2 years</u>   |                                       |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)  |                                |  |                                       |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                |  |                                       |
| 19a. DATE OF OPERATION  |                                | 19b. MAJOR FINDINGS OF OPERATION                                       |                                       |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                |  |                                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                                | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) |                                       |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)  |                                |  |                                       |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)  |                                | 21e. HOW DID INJURY OCCUR?   |                                       |
| 21f. HOW DID INJURY OCCUR?  |                                |  |                                       |
| 22. I hereby certify that I attended the deceased from <u>June 1954</u> to <u>Oct 15, 1956</u> , that I last saw the deceased alive on <u>Oct 14, 1956</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above. |                                |  |                                       |
| SIGNATURE <u>Harold H. Burns</u>  |                                | DATE SIGNED <u>10-16-56</u>  |                                       |
| ADDRESS (Street, city, town, state) <u>115 E. Eager St</u>  |                                |  |                                       |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |                                | 24. DATE THEREOF <u>10-17-56</u>                                       |                                       |
| NAME OF CEMETERY OR CREMATORY <u>Trinity Convent Cem.</u>   |                                | LOCATION (City, town, or county) <u>Ilwaco</u>                         |                                       |
| 24. REC'D BY REGISTRAR  |                                | 25. FUNERAL DIRECTOR'S SIGNATURE                                       |                                       |
| REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>   |                                | ADDRESS <u>Barley Funeral Home, Catonsville, Md.</u>                   |                                       |

POSTAL W. S.

1880-1881



10000

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                           |  |                                    |
|---|---------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>                      |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklandville</u>  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklandville</u>   |                                    |
| c. LENGTH OF STAY IN 1b <u>Life</u>   |                           | d. STREET ADDRESS <u>Green Spring Ave</u>  |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Green Spring Ave</u>  |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                    |
| 3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>BROWN JR</u> Middle <u>BROWN JR</u> Last   |                           | 4. DATE OF DEATH <u>Oct</u> Month <u>7</u> Day <u>9</u> Year <u>1956</u>   |                                    |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb-5-1880</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs.  |                           | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANKER</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>   |                                    |
| 11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>   |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                    |
| 13. FATHER'S NAME <u>George Brown</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Frances Linchster</u>  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                           | 16. SOCIAL SECURITY NO. <u>-</u>   |                                    |
| 17. INFORMANT <u>Mr. Harry Black Stevenson Md.</u> Address  |                           |  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma - Liver</u><br>DUE TO (b) <u></u><br>DUE TO (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                           | INTERVAL BETWEEN ONSET AND DEATH <u>3 mo?</u>  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |  |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that I attended the deceased from <u>June 1956</u> to <u>Oct 7 1956</u> that I last saw the deceased alive on <u>Oct 7 1956</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.  |                           |  |                                    |
| ACTUAL SIGNATURE <u>Walter A Baetjer</u> M.D.   |                           | ADDRESS (Street, city or town, state) <u>1101 St Paul St</u>   |                                    |
| PHYSICIAN'S NAME (Type) <u>WALTER A BAETJER</u>   |                           | DATE SIGNED  |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 22b. DATE THEREOF <u>10-9-56</u>   |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT</u>   |                           | 22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>  |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins</u> ADDRESS <u>4905 York Rd.</u>   |                           | 24a. REC'D BY REGISTRAR DATE <u></u>   |                                    |
|   |                           | 24b. REGISTRAR'S SIGNATURE <u>V. H. Gray</u>   |                                    |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be attached for use as the burial-transit permit. Then please remove carbon papers.

The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

OCT 9 1956

RECEIVED

44

## MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

U.S. DEPARTMENT OF JUSTICE

1956

RECEIVED  
JUL 10 1956

# STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

09975

## 10002 CERTIFICATE OF DEATH

Reg. Dist. No. 15

|   |                                  |   |                                 |  |   |   |   |
|---|----------------------------------|---|---------------------------------|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore County</u><br><u>7920 Bridge Ave.</u> MARYLAND  |                                  |   |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Baltimore</u><br>b. COUNTY <u>Baltimore</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Chesaco Pk.</u>  |                                  |   |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>   |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  |   |                                 | d. STREET ADDRESS<br><u>7920 Bride. Ave.</u>   |   |   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Frank</u> First Middle Last <u>Bubczyk</u>  |                                  |   |                                 | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>17,</u> Year <u>1956</u>  |   |   |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                     | 8. DATE OF BIRTH<br><u>1887</u> | 9. AGE (In years last birthday)<br><u>69</u> yrs   | IF UNDER 1 YEAR<br>Months <u>17,</u> Days <u>1956</u> |   | IF UNDER 24 HRS.<br>Hours <u>1956</u> Min   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer</u>   |                                  |   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Poland</u>        |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                  |   |                                 | 13. FATHER'S NAME<br><u>G. Bubczyk</u>   |   |   |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Maryx BubczykxxxWife</u>   |                                  |   |                                 | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |   |   |   |
| 16. SOCIAL SECURITY NO.   |                                  |   |                                 | 17. INFORMANT<br><u>Mary Bubczyk Wife</u> Address  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Miliary tuberculosis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary tuberculosis</u><br>DUE TO (c) |                                  |   |                                 |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 weeks</u><br><u>10 years</u>                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |                                 |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                              |   |
| 21. I certify that I attended the deceased from <u>April 1952</u> 19 <u>Oct.</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 17,</u> 19 <u>56</u> , and that death occurred at <u>10:15p</u> M, from the causes and on the date stated above.  |                                  |   |                                 |  |   |   |   |
| ACTUAL SIGNATURE <u>James R. Mason M.D.</u>   |                                  |   |                                 | ADDRESS (Street, city or town, state) <u>8019 Philadelphia Rd.</u>   |   |   |   |
| PHYSICIAN'S NAME (Type) <u>James R. Mason, M. D.</u>  |                                  |   |                                 | DATE SIGNED <u>10-18-56</u>  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>Oct. 15/56</u>  |                                 | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Holy Posary</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore</u> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Fred W. Ozazewski</u> ADDRESS <u>1930 Eastern Ave.</u>   |                                  |   |                                 | 24a. REC'D BY REGISTRAR<br>DATE <u>Oct. 17, 1956</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>Mrs. Edith Hurley</u>            |   |

BUREAU V. S.

OCT 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09976

19003

CERTIFICATE OF DEATH

Reg. Dist. No.

44

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY                                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>14 DAYS</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |  |   |  | e. STREET ADDRESS<br><b>2215 PULASKI STREET</b>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CORNELL</b> Middle <b>J.</b> Last <b>BULLOCK</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>21</b> Year <b>1956</b>   |  |   |  |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>NEGRO</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2-17-09</b>  |  |
| 9. AGE (In years last birthday) yrs. <b>47</b>   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MESSENGER</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOSPITAL</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>NORFOLK, VIRGINIA</b>                                     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>THOMAS BULLOCK</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>LUCEY HENDERSON</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b> (If yes, give war or dates of service) <b>WW-11</b>   |  | 16. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>   |  | 17. INFORMANT<br>Address<br><b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MALIGNANT HYPERTENSION</b><br>DUE TO<br>(c)   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 MONTH</b><br><b>6 MONTHS</b>                                     |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>PARALYTIC ILEUS - Duration, 6 Days</b>   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                    |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>o. n.</b> p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)   |  | (County)  |  | (State)   |  |
| 21. I certify that I attended the deceased from <b>Oct. 7, 1956</b> , to <b>Oct. 21, 1956</b> , and that death occurred at <b>3:10 A.M.</b> , from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>10-21-56</b><br>ACTUAL SIGNATURE <b>Armen Bobosian</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>ARMEN BOBOSIAN</b> M.D. <b>VAH, FORT HOWARD, Maryland</b> <b>10-21-56</b> |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 22b. DATE THEREOF<br><b>10-24-56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>BALTIMORE MARYLAND</b>                                |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Arlington S. Phillips, 1808 N. Monroe St. Balto. Md.</b>  |  |   |  | 24. REC'D BY REGISTRAR<br><b>ctz</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Harmon X</b>   |  |

MEDICAL CERTIFICATION

3 A 177.





10004

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH.

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) North Point Village LENGTH OF STAY (in this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 7922 St. Clare Lane

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town) North Point Village  
 STREET ADDRESS (If rural give location) 7922 St. Clare Lane

3. NAME OF DECEASED: (First) (Middle) (Last)  
MARY SOPHIA CARLIN

4. DATE (Month) (Day) (Year)  
 OF DEATH: Oct. 29, 1956.

5. SEX: Female 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH: Nov. 18, 1885

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.  
70 yrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
House Work

10B. KIND OF BUSINESS OR INDUSTRY:  
At Home

11. BIRTHPLACE (State or foreign country):  
Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

## 13 FATHER'S NAME:

Adam Hock

## 14. MOTHER'S MAIDEN NAME:

Margaret Schindhelm

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no None

16. SOCIAL SECURITY NO.  
None

## 17. INFORMANT &amp; ADDRESS:

James A. Carlin Same

18. MEDICAL CERTIFICATION  
 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

## ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(A) Congestive Heart Failure

(B) Coronary Sclerotic Heart Dis.

(C)

INTERVAL BETWEEN ONSET AND DEATH

14 days

?10 years

## 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

0

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D TIME (Month) (Day) (Year) (Hour) OF INJURY

21E INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1956, to Oct 30, 1956 that I last saw the deceased alive on Oct 29, 1956, and that death occurred at 7:55 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BURIAL 11-2-56 SACRED HEART CEM 7401 GERMAN HILL RD., MD.

11-1-57 W. H. Hedrick Charles J. Gailer 901 S. CONNELL ST. BALTO., MD.

MARGIN RESERVED FOR BINDING

VS. A15-10-5

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

52: D S

10005

CERTIFICATE OF DEATH

Reg. Dist. No.

44

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b><br>c. LENGTH OF STAY IN 1b<br><b>1 Day</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Veterans Administration Hospital</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>d. STREET ADDRESS<br><b>103 Warren Avenue</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>THOMAS J. CHAMBERS</b>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>October 24 19 56</b>   |  |   |   |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>November 20, 1892</b>                            |   |
| 9. AGE (In years last birthday)<br><b>63</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | 11. IF UNDER 24 HRS<br>Months Days Hours Min.   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                         |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Manufacturing Co.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b> |   |
| 13. FATHER'S NAME<br><b>Charles C. Chambers</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Bridgett MN: Stapleton</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>Yes</b>  |  | 16. SOCIAL SECURITY NO.<br><b>WW I 217-05-4941</b>  |  | 17. INFORMANT<br>Address<br><b>Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Maryland</b>   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE WITH AORTIC STENOSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b><br>(c) <b>UNKNOWN</b> |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                    |   |
| 21. I certify that I attended the deceased from <b>October 23, 1956</b> , to <b>October 24, 1956</b> and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>C. J. Papastrat, M.D. M.D. VAH, FORT HOWARD, MARYLAND 10/25/56</b>        |  |   |  |   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   |  |   |  |   |   |
| 22b. DATE THEREOF<br><b>10-29-56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cemetery</b>                                  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. Cook-Blight, Inc.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>10/25/56</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Shawson &amp; Marking</b>              |   |

RECEIVED  
JAN 10 1964  
U. S. DEPT. OF JUSTICE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09979

10006

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY                           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>   |   | c. LENGTH OF STAY IN 1b<br><b>101 Days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Veterans Administration Hospital</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>WILLIAM W. CHANEY</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>October 22 1956</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 4, 1888</b>                |
| 9. AGE (In years last birthday)<br><b>68</b> yrs   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Tree Trimmer</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Savage, Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 13. FATHER'S NAME<br><b>Samuel Chaney</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Frances Tucker</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |   | 16. SOCIAL SECURITY NO.<br><b>220-01-2640</b>   |   |
| 17. INFORMANT<br><b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Mdd.</b>   |   | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b><br>DUE TO<br><b>450.0</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b><br><b>UNKNOWN</b> |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                    |
| 21. I certify that I attended the deceased from <b>July 13, 1956</b> , to <b>October 22, 1956</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>M.D. YAH, FORT HOWARD, MARYLAND 10/23/56</b>  |   |   |   |
| ACTUAL SIGNATURE<br><b>C. J. PAPASTRAT, M.D.</b>   |   |   |   |
| PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M.D.</b>   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>10-26-56</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cemetery Baltimore, Maryland</b>  | 22d. LOCATION (City, town, or county) (State)           |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. Cook-Blight, Inc. 6009 Harford Road Baltimore 14, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br><b>DATE 3-1-1960</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Harrison L. Farber</b> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. WATSON

1956

10

RECEIVED

10007

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

|  |                                  |   |                                   |  |   |   |  |
|--|----------------------------------|---|-----------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>  |                                  |   |                                   | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>   |                                  |   |                                   | c. LENGTH OF STAY IN 1b<br><b>3 days</b>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Veterans Administration Hospital</b>   |                                  |   |                                   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JEROME</b> Middle <b>E</b> Last <b>CHARTERS</b>  |                                  |   |                                   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>15</b> Year <b>19 56</b>   |   |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/2/96</b> | 9. AGE (In years last birthday) yrs.<br><b>60</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machinist</b>  |                                  |   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Crown Cork &amp; Seal Mfgs.</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                      |  |
| 13. FATHER'S NAME<br><b>Sylvester Charters</b>   |                                  |   |                                   | 14. MOTHER'S MAIDEN NAME<br><b>Lena Fludung</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)<br><b>Yes</b> <b>WWI</b>   |                                  |   |                                   | 16. SOCIAL SECURITY NO<br><b>216-09-8418</b>   |   | 17. INFORMANT<br><b>Clin. Rec. Vets. Admin. Hosp. Ft. Howard, Md.</b>                             |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>THROMBOSIS, LEFT MIDDLE CEREBRAL ARTERY</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)                          |                                  |   |                                   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>  |                                  |   |                                   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                               |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. ft. p. m. <b>19</b>  |                                  |   |                                   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
|  |                                  |   |                                   | 20f. (City or town)  |   | (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>October 12, 1956</b> , to <b>October 15, 1956</b> , that I attended the deceased and that death occurred at <b>7:40 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Fort Howard, Maryland</b> <b>10/16/56</b> |                                  |   |                                   |  |   |   |  |
| ACTUAL SIGNATURE <b>C. J. Papastrat M.D.</b>   |                                  |   |                                   | M.D. <b>Veterans Administration Hospital</b>   |   |   |  |
| PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M.D.</b>   |                                  |   |                                   | Fort Howard, Maryland  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Oct. 19, 1956</b>   |                                   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Burgee Funeral Home</b><br><b>Horace F. Burgee, Jr.</b>   |                                  |   |                                   | ADDRESS<br><b>3631 Falls Rd., Balto., Md.</b>  |   | 24a. REC'D BY REGISTRAR<br><b>Oct. 17, 1956</b>   |  |
|  |                                  |   |                                   | 24b. REGISTRAR'S SIGNATURE<br><b>Dawson L. Larkins</b>   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
OCT 18 1956  
BUREAU



1

INSTRUCTIONS

24 hours after death, executed by the registrar within 72 hours after death. After this certificate has been executed by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09981

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

10008

|  |                              |  |   |   |  |  |  |
|--|------------------------------|--|---|---|--|--|--|
| 1. PLACE OF DEATH<br>COUNTY <u>BALTIMORE</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u><br>TOWN <u>19 YEARS</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>  |                              |  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>MD</u> COUNTY<br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u><br>OR<br>TOWN <u>2502 N. CALVERT ST.</u><br>STREET ADDRESS (If rural give location) |  |  |  |
| 3. NAME OF DECEASED<br>(Type or Print) (First) (Middle) (Last)<br><u>GERTRAUDE MAY CLARKE</u>  |                              |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>Oct. 9 1956</u>  |   |  |  |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>  | 8. DATE OF BIRTH<br><u>10/20/1872</u>   | 9. AGE last birthday<br><u>83</u> yrs.  | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><u>PENNA.</u>  |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>US</u>  |                              |  | 13. FATHER'S NAME<br><u>THEODORE MONTGOMERY</u>   |   |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>HARRIET DUBOSS</u>  |                              |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)<br><u>NO</u> |   |  |  |  |
| 16. SOCIAL SECURITY NO.<br><u>NONE</u>   |                              |  | 17. INFORMANT'S ADDRESS<br><u>Paul L. Smith, Jr.<br/>Cockeysville, Md.</u>  |   |  |  |  |
| 18. MEDICAL CERTIFICATION<br>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br>IMMEDIATE CAUSE (A) <u>Arterio-Sclerotic Cardia</u><br>ANTECEDENT CAUSE(S) DUE TO (B) <u>Vascular disease</u><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)<br>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. |                              |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 years</u>  |  |  |  |
| 19a. DATE OF OPERATION   |                              | 19b. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |   | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)  |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                              | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>8/7</u> , 19 <u>50</u> , to <u>10/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/9</u> , 19 <u>56</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.<br>SIGNATURE <u>Walter J. Kus</u> M.D. <u>Cockeysville Md.</u> DATE SIGNED <u>10/9/56</u><br>ADDRESS (Street, city, town, state)                        |                              |  |   |   |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>  |                              | DATE THEREOF<br><u>10-13-56</u>  |   | NAME OF CEMETERY OR CREMATORY<br><u>Green Mount</u>   |  |  |  |
| 24. REC'D BY REGISTRAR<br>DATE <u>Oct 11</u>   |                              | REGISTRAR'S SIGNATURE<br><u>Wm Cook</u>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Wm Cook</u>  |  |  |  |
| 26. ADDRESS<br><u>1217 St. Paul St</u>   |                              |  |   |   |  |  |  |

10

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 1809982 3 ✓

10009

## CERTIFICATE OF DEATH

Reg. Dist. No. 12

|  |                                  |   |  |   |   |   |  |
|--|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Pikesville</u>  |                                  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Pikesville</u>                             |   |   |  |
| c. LENGTH OF STAY IN 1b<br><u>8 yrs.</u>   |                                  |   |  | d. STREET ADDRESS<br><u>726 Howard Road</u>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Myrtle</u> <u>Lee</u> <u>Cohee</u>   |                                  |   |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>24</u> Year <u>1956</u>   |   |   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Jan. 17, 1875</u> | 9. AGE (In years, last birthday) <u>81</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> | IF UNDER 24 HRS<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                                  |   |  | 13. FATHER'S NAME<br><u>Daniel K. Gootee</u>  |   |   |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Anna R. Griffith</u>  |                                  |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>       |   |   |  |
| 16. SOCIAL SECURITY NO.<br><u>none</u>   |                                  |   |  | 17. INFORMANT<br>Address <u>Pikesville</u><br><u>Mrs. Louise Draper, 726 Howard Rd.</u>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of Breast</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>  </u><br>DUE TO (c) <u>  </u> |                                  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 yrs.</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |                                  |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>  </u> a. m. <u>19</u> p. m.  |                                  |   |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>                               |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
| 20f. (City or town)  |                                  |   |  | (County)  |   | (State)   |  |
| 21. I certify that I attended the deceased from <u>AUG.</u> , 19 <u>51</u> , to <u>OCTOBER 24, 1956</u> , that I last saw the deceased alive on <u>OCTOBER 24, 1956</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above.                                      |                                  |   |  |   |   |   |  |
| ACTUAL SIGNATURE <u>James A. Miller M.D.</u>   |                                  |   |  | ADDRESS (Street, city or town, state) <u>1331 Reisterstown Rd. Pikesville, Md.</u>  |   |   |  |
| PHYSICIAN'S NAME (Type) <u>James A. Miller M.D.</u>  |                                  |   |  | DATE SIGNED <u>10/25/56</u>   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>Oct 27, 1956</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Concord Cemetery</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Caroline County, Md.</u>                      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>J. Vogel</u>  |                                  |   |  | ADDRESS<br><u>Pharmacia, Inc.</u>   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>10/27/56</u>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>  </u>  |                                  |   |  | 24c. REGISTRAR'S SIGNATURE<br><u>  </u>   |   |   |  |

RECEIVED V. S.

OCT

RECEIVED V. S.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09983

10010

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

|   |                                 |  |                                |  |  |  |  |
|---|---------------------------------|--|--------------------------------|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                 |  |                                | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>   |                                 |  |                                | c. LENGTH OF STAY IN 1b <b>66 Days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>   |                                 |  |                                | d. STREET ADDRESS <b>1413 Lemmon Street</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>H.</b> Last <b>COOK</b>  |                                 |  |                                | 4. DATE OF DEATH Month <b>October</b> Day <b>14</b> Year <b>19 56</b>  |  |  |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>Colored</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>8/5/97</b> | 9. AGE (In years last birthday) <b>59</b> yrs.   | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY <b>Seed Company</b>  |                                | 11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                               |  |
| 13. FATHER'S NAME <b>Jerry Cook</b>   |                                 |  |                                | 14. MOTHER'S MAIDEN NAME <b>Hester Scipio</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW-I</b>  |                                 | 16. SOCIAL SECURITY NO. <b>217 03 9983</b>   |                                | 17. INFORMANT Address <b>Clin.Rec.Vet.Adm.Hosp., Ft.Howard, Maryland</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SQUAMOUS CELL CARCINOMA OF LEFT LUNG</b><br><b>100X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                 |  |                                |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                 | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                     |  |
| 21. I certify that I attended the deceased from <b>August 9, 1956</b> , to <b>October 14, 1956</b> , that I last saw the deceased alive on <b>October 14, 1956</b> , and that death occurred on <b>October 14, 1956</b> at <b>11:40 A.M.</b> , from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Maryland</b> DATE SIGNED <b>10/14/56</b>  |                                 |  |                                |  |  |  |  |
| ACTUAL SIGNATURE <b>C.M. Snyder M.D.</b>  |                                 | PHYSICIAN'S NAME (Type) <b>C.M. SNYDER, M.D.</b> <b>VAH, Fort Howard, Maryland</b>   |                                |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                                 | 22b. DATE THEREOF <b>Oct. 17, 1956</b>   |                                | 22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Katie Williams</b>  |                                 | ADDRESS <b>322 N. Schroeder St.</b>  |                                | 24a. REC'D BY REGISTRAR <b>17 1956</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>James H. Farber</b>                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file them with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

17 1956

RECEIVED

10011

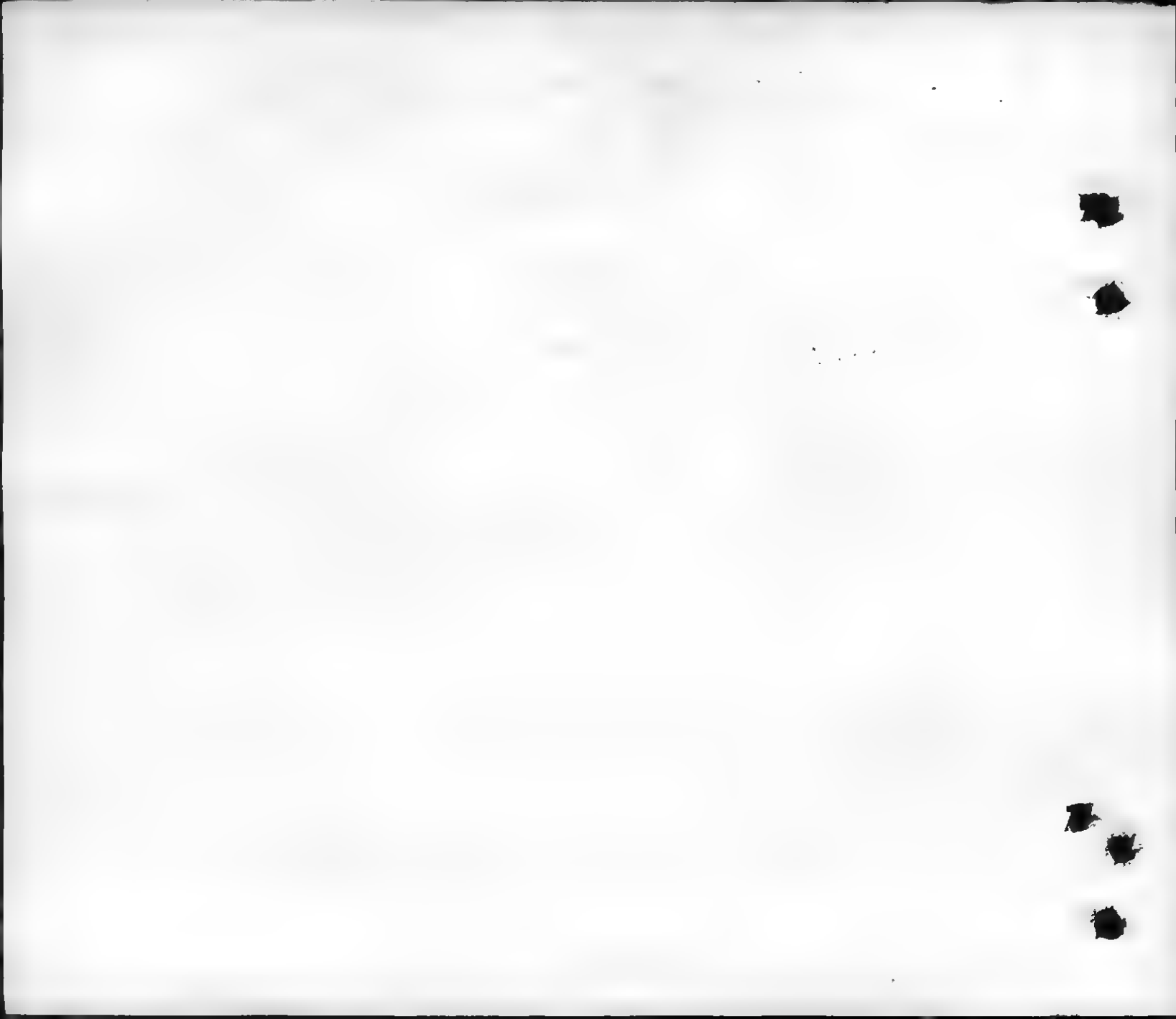
## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |                                       |
|---|--|--|---------------------------------------|
| 1. PLACE OF DEATH   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                                       |
| COUNTY <u>Baltimore</u>   | MARYLAND   | STATE <u>md</u>  | COUNTY <u>Baltimore</u>               |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Pikesville</u>   | LENGTH OF STAY (In this place)<br><u>5 1/2 yrs</u> | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Pikesville</u> |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>125 Slade</u>   |  | STREET ADDRESS (If rural give location)<br><u>125 Slade Ave.</u>                                   |                                       |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br>(Type or Print) <u>Bertha Schaefer Cox</u>  |  | 4. DATE (Month) (Day) (Year)<br>OF DEATH: <u>Oct. 4</u> 19 <u>66</u>                               |                                       |
| 5. SEX. <u>Female</u>   | 6. COLOR OR RACE. <u>White</u>                     | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>                                   | 8. DATE OF BIRTH. <u>Jan. 14 1916</u> |
| 9. AGE last birthday <u>80 yrs.</u>   |  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>   |  | 10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>   |                                       |
| 11. BIRTHPLACE (State or foreign country): <u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                       |
| 13. FATHER'S NAME: <u>John Schaefer</u>   |  | 14. MOTHER'S MAIDEN NAME: <u>Margaret Maiseh</u>   |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>  |  | 16. SOCIAL SECURITY NO. <u>none</u>  |                                       |
| 17. INFORMANT'S ADDRESS: <u>Mr J W Cox, 125 Slade Ave, Pikesville</u>   |  |  |                                       |
| 18. MEDICAL CERTIFICATION   |  |  | INTERVAL BETWEEN ONSET AND DEATH      |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |                                       |
| IMMEDIATE CAUSE (A) <u>Generalized arteriosclerosis</u>   |  |  | <u>2 yrs.</u>                         |
| ANTECEDENT CAUSE (B) DUE TO   |  |  |                                       |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |  |  |                                       |
| (C) DUE TO  |  |  |                                       |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |                                       |
| 19A. DATE OF OPERATION:   |  | 19B. MAJOR FINDINGS OF OPERATION   |                                       |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                             |                                       |
| 21C. WHERE DID (City or town) (County) (State)  |  | 21D. HOW DID INJURY OCCUR?   |                                       |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |                                       |
| 22. I hereby certify that I attended the deceased from <u>July, 1956</u> to <u>4 Oct, 1966</u> that I last saw the deceased alive on <u>3 Oct, 1956</u> and that death occurred at <u>10.... M.</u> from the causes and on the date stated above. |  |  |                                       |
| SIGNATURE <u>Paul H Royse</u>   |  | DATE SIGNED <u>4 Oct 56</u>  |                                       |
| ADDRESS <u>Pikesville 8 Md</u>  |  |  |                                       |
| M. D. <u>Pikesville 8 Md</u>  |  |  |                                       |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | DATE THEREOF <u>10-6-56</u>  |                                       |
| NAME OF CEMETERY OR CREMATORY <u>Graceland Ridge</u>  |  | LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>                                     |                                       |
| DATE REC'D BY LOCAL REGISTRAR <u>10-4-66</u>  |  | REGISTRAR'S SIGNATURE <u>L</u>   |                                       |
| 24. FUNERAL DIRECTOR <u>Frank H. Newell</u>   |  | ADDRESS <u>Pikesville, Md.</u>   |                                       |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09985

10012

CERTIFICATE OF DEATH

Reg. Dist. No.

38

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>                     |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>   |  |   |  | c. LENGTH OF STAY IN 1b   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>8 Aintree Rd.</u>  |  |   |  | e. STREET ADDRESS<br><u>8 Aintree Rd.</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>LAMBERT</u> Middle <u>FOSTER</u> Last <u>CROMWELL</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>29</u> Year <u>1956</u>  |  |  |  |
| 5. SEX<br><u>male</u>   |  | 6. COLOR OR RACE<br><u>white</u>                              |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>April 18, 1880</u>                              |  |
| 9. AGE (In years last birthday)<br><u>76</u> yrs.   |  | IF UNDER 1 YEAR<br>Months _____ Days _____                    |  | IF UNDER 24 HRS.<br>Hours _____ Min. _____  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Plant Engineer - Rtd</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>C. &amp; P. Tel. Co.</u>  |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Md.</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |  |  |
| 13. FATHER'S NAME<br><u>Lambert Cromwell</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Laura Morgan</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>  |  |   |  | 16. SOCIAL SECURITY NO.   |  |  |  |
| 17. INFORMANT<br><u>Mrs. Winifred Cromwell - 8 Aintree Rd., Towson</u>  |  |   |  | Address   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u><br>DUE TO <u>Arterio Sclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>a. m.</u> <u>19</u> p. m.   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)   |  |   |  | 20g. (County)   |  | 20h. (State)   |  |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>36</u> to <u>29 Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>29 Oct</u> , 19 <u>56</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Charles H. Kiser</u> M.D.   |  |   |  | ADDRESS (Street, city or town, state) <u>6701 York Rd., Baltimore, Md.</u>  |  |  |  |
| DATE SIGNED <u>Nov 5 1956</u>   |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |   |  |   |  |  |  |
| 22b. DATE THEREOF<br><u>11/1/56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Druid Ridge Cem.</u> |  | 22d. LOCATION (City, town, or county) (State)<br><u>Pikesville, Md.</u>   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Wm. J. Kiser &amp; Sons - Balt. 17 Md.</u>   |  |   |  | 24a. RECEIVED BY REGISTRAR<br><u>Nov 1, 1956</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Walter Gray</u>                       |  |

BUREAU V. B.

OV 2 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09986

9972

## CERTIFICATE OF DEATH

Reg. Dist. No.....

|   |                                    |  |   |
|---|------------------------------------|--|---|
| 1. PLACE OF DEATH<br>COUNTY <u>Baltimore</u> MARYLAND   |                                    | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Maryland</u> COUNTY                            |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Undale, 22,</u>                                    |                                    | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Undale, 22,</u> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>209 CENTER STREET</u>   |                                    | STREET ADDRESS (If rural give location)<br><u>209 CENTER STREET</u>                              |   |
| 3. NAME OF DECEASED<br>(Type or Print) <u>LOUIS</u>   | (First) (Middle) (Last)            | 4. DATE OF DEATH<br><u>October 13, 1956</u>  | (Month) (Day) (Year)  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>Colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED<br>(Specify) <u>MARRIED</u>                                | 8. DATE OF BIRTH<br><u>March 10, 1911</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Truck Driver for Railroad Co.</u> |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Railroad</u>   | 9. AGE last birthday<br><u>45</u> yrs. <u>7</u> months <u>3</u> days <u>1</u> hour <u>10</u> min. |
| 11. BIRTHPLACE (State or foreign country)<br><u>CHETESOUTH Carolina</u>   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |   |
| 13. FATHER'S NAME<br><u>JIM Crosby</u>  |                                    | 14. MOTHER'S MAIDEN NAME<br><u>MARY HILL</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>  |                                    | 16. SOCIAL SECURITY No.<br><u>705-10-9516</u>  |   |
| (If yes, give war or dates of service)  |                                    | 17. INFORMANT<br><u>INETTA Crosby</u>  |   |

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Broncho-pneumonia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma of Spine (C-5)

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

2 days

7 months

|  |   |                       |          |         |
|--|---|-----------------------|----------|---------|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)    | PLACE (Home, farm, factory, street, office bldg., etc.)   | (CITY OR TOWN)        | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? |          |         |

22. I hereby certify that I attended the deceased from July 10, 1956, to October 13, 1956, that I last saw the deceased

alive on October 13, 1956, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

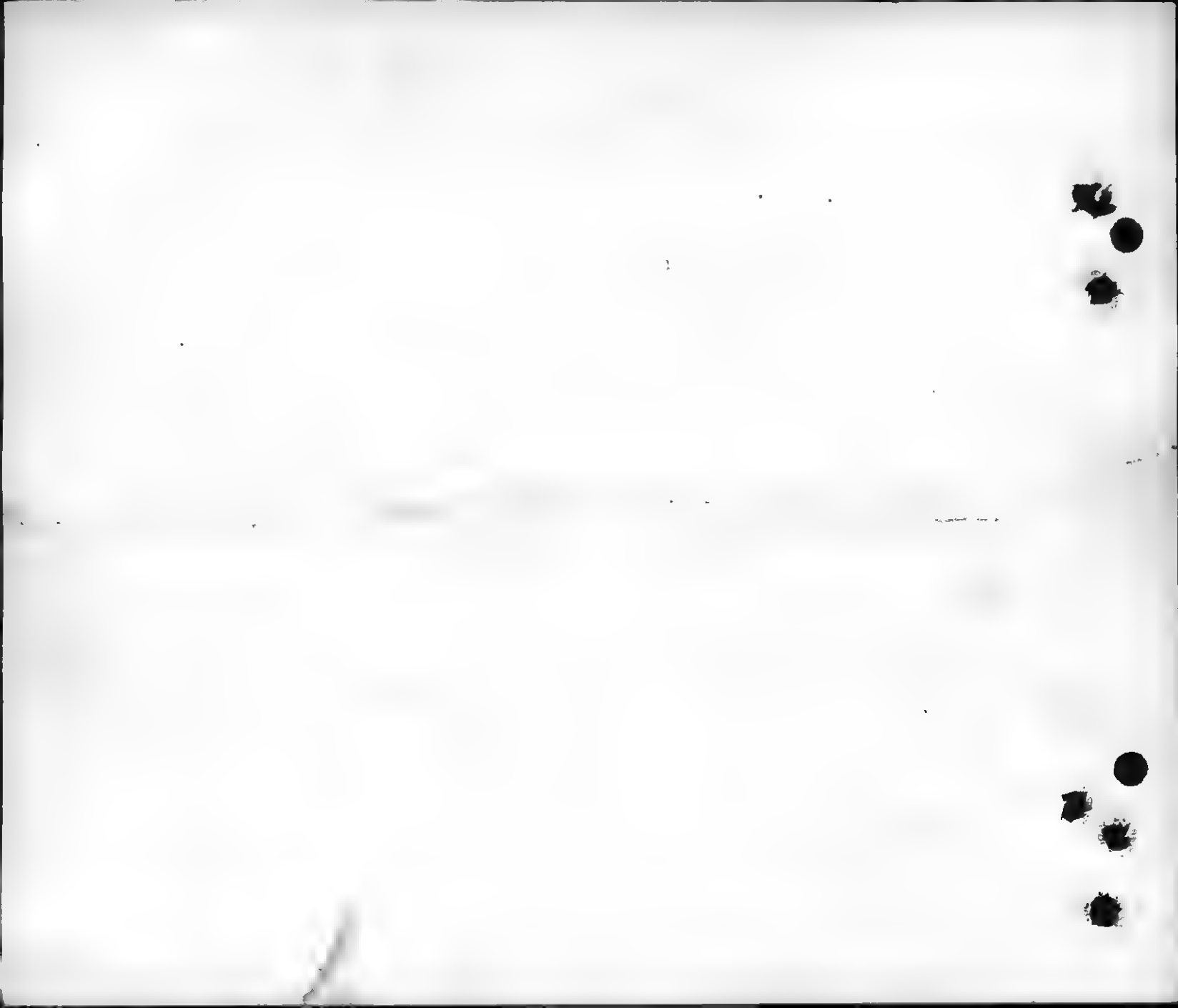
ADDRESS

DATE SIGNED

|   |                       |                               |                                  |         |
|---|-----------------------|-------------------------------|----------------------------------|---------|
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF          | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| <u>Removal</u>                          | <u>Oct 17/56</u>      | <u>Piney Grove Cem.</u>       | <u>Chesapeake, S. C.</u>         |         |
| DATE REC'D BY LOCAL REG.                | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR          | ADDRESS                          |         |
| <u>Oct. 17, 1956</u>                    | <u>A. H. Hedrick</u>  | <u>Mrs. Frank T. Elickson</u> | <u>1129th Cedar St.</u>          |         |

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09987

10013

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |   |  |
|---|---|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)<br>a. STATE <u>Maryland.</u> b. COUNTY <u>Baltimore</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ODonnell Hgts</u>  |   | c. LENGTH OF STAY IN 1b<br><u>20 yrs</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>6100 Shipview Ave</u>  |   | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ODonnell Hgts</u>  |  |
| 3 NAME OF DECEASED (Type or print)<br>First <u>Mary</u> Middle <u>F.</u> Last <u>Crouse</u>   |   | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>16</u> Year <u>19 56</u>   |  |
| 5 SEX<br><u>F.</u>  | 6. COLOR OR RACE<br><u>W.</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>June 22, 1897</u>          |
| 9. AGE (In years last birthday) yrs. <u>59</u>  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>H.W.</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>O.H.</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Va.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Louis Simmons</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Ida</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><u>John H. Crouse, 6100 Shipview Ave</u>   |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Coronary heart disease</u><br>DUE TO<br>(c) <u>Coronary occlusion</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 wk.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. <u>11</u> p. m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)             |
| 21. I certify that I attended the deceased from <u>Jan. 1, 1953</u> , to <u>Oct. 16, 1956</u> , that I last saw the deceased alive on <u>Oct. 16, 1956</u> , and that death occurred at <u>PM</u> , from the causes and on the date stated above.   |   |   |  |
| ACTUAL SIGNATURE<br><u>Dr. F. Frederick Ruzicka</u>   |   | ADDRESS (Street, city or town, state) DATE SIGNED   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |   | 22b. DATE THEREOF<br><u>Oct. 19/56</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Oaklawn Cem.</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Balto. Co. Md.</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Harry H. Witzke</u>  |   | 24a. REC'D BY REGISTRAR<br><u>4101 Edmondson Ave</u>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>Tom Kelly</u>  |   | DATE<br><u>OCT 22</u>   |  |

RECEIVED

OCT 28 1956

U.S. AIR FORCE

10014

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>Balto.</b>                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>House in Pines, 16 Fusting Ave</b>   |                                  | d. STREET ADDRESS<br><b>508 Lafayette Ave</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Margaret E. Cupero</b>   |                                  | 4. DATE OF DEATH Month Day Year<br><b>Oct. 23/56</b> 19   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 28, 1880</b> |
| 9. AGE (In years lost birth day) yrs.<br><b>76</b>  |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>H.W.</b>   |   |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |                                  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?  |                                  |   |   |
| 13. FATHER'S NAME<br><b>Charles J. Hachtel</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Emma Kull</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Mrs. Garland Milburn</b>  |                                  | Address<br><b>151 E. Palisade Ave.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio-vascular disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Parkinson's syndrome</b><br>DUE TO<br>(c)                     |                                  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>May 6, 1946</b> , to <b>October 23, 1956</b> , that I last saw the deceased alive on <b>October 23, 1956</b> , and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>4116 Edmondson Avenue</b> DATE SIGNED <b>10/25/56</b> |                                  |   |   |
| ACTUAL SIGNATURE _____ M.D. <b>George A. Knipp, M.D.</b>  |                                  |   |   |
| PHYSICIAN'S NAME (Type) <b>George A. Knipp, M.D.</b>  |                                  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Oct. 25/56</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Western Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Harry H. White</b>   |                                  | 24a. RECEIVED BY REGISTRAR<br>DATE <b>Oct 25 1956</b>   |   |
| ADDRESS<br><b>101 Edmondson Ave.</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>T. E. Harry</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. The funeral director should be notified of the death of the deceased. The funeral director should be notified of the death of the deceased. The funeral director should be notified of the death of the deceased.

TO REGISTRAR: The registrar should be notified of the death of the deceased. The registrar should be notified of the death of the deceased. The registrar should be notified of the death of the deceased.

NAVY

1956

NAVY



## CERTIFICATE OF DEATH

Reg. Dist. No.

30

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE CO.</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write street and town)<br><b>CATONSVILLE</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>10 days</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE 7</b> |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>  |                                  | d. STREET ADDRESS<br><b>2601 POPULAR DRIVE</b>   | e. IS RESIDENCE ON A FARM<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SAMUEL</b> Middle <b>DARRAH</b> Last <b>DARRAH</b>   |                                  | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>13</b> Year <b>1956</b>  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>5-24-70</b>   |
| 9. AGE (In years last birthday)<br><b>86</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>                  | IF UNDER 24 HRS.<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/>                       |
| 10a. USUAL OCCUPATION (Give kind of work done during last year, even if retired)<br><b>SALESMAN</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>COAL STOVE CO.</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>NEW YORK</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>DAVID DARRAH</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET BUSH</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br><b>UNKNOWN</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>489-16-7822</b>  |  |
| 17. INFORMANT<br>Address <b>Charts SPRING GROVE STATE HOSPITAL</b>   |                                  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary and generalized arteriosclerosis</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral nephrolithiasis</b> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3-4 days</b><br><br><b>years</b>                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                 |
| 20f. (City or town) (County) (State)   |                                  | 20g. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>OCT. 3, 1956</b> to <b>OCT. 13, 1956</b> that I last saw the deceased alive on <b>OCT. 13, 1956</b> , and that death occurred at <b>5:05 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>10/15/56</b> DATE SIGNED  |                                  |  |  |
| ACTUAL SIGNATURE <b>Charles W. Ward</b> M.D.   |                                  | DATE SIGNED <b>10/15/56</b>  |  |
| PHYSICIAN'S NAME (Type)  |                                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Entombment</b>   |                                  | 22b. DATE THEREOF<br><b>10/16/56</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Mausoleum</b>  |
| 22d. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Md.</b>  |                                  | 22e. LOCATION (City, town, or county) (State)  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ellsworth Armacost</b> ADDRESS<br><b>Ellsworth Armacost-4600 Liberty Hghts. Ave.</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>DATE</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>DATE</b>  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. S.

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10016

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Balto.</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Pa.</u> b. COUNTY   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hillsideville</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Allentown</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Belair Rd.</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Russel Charles DeEsch</u>  |  | 4. DATE OF DEATH Month Day Year<br><u>OCTOBER 5 1956</u>   |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                   | 8. DATE OF BIRTH<br><u>5-14-31</u>                                 |
| 9. AGE (in years last birthday)<br><u>25</u> yrs.  |  | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HRS<br>Hours Min.                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Ensign</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>US Navy</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Pa</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 13. FATHER'S NAME<br><u>Charles E. DeEsch</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Catherine Acker</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>yes</u>   |  | 16. SOCIAL SECURITY NO.<br><u>currently</u>  |  |
| 17. INFORMANT<br><u>U S Navy</u>   |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Concussion &amp; laceration Brain injury</u><br>DUE TO <u>Head wounds &amp; contusions forces</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Sustained in car crash.</u><br>DUE TO <u>Sustained in car crash.</u>                        |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Just</u>                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Crush injury of chest.</u>   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>CAR CRASHED INTO WALL</u>   |  |
| 20c. TIME OF INJURY Month, Day, Year<br><u>5:30 a.m. 10-8-56</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Street</u>  | 20f. (City or town) (County) (State)<br><u>Ringsville Balto Md</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |  |  |
| ACTUAL SIGNATURE<br><u>John C. Hyle</u>  |  | DATE SIGNED<br><u>10-8-56</u>  |  |
| EXAMINER'S NAME (Type)<br><u>JOHN C. Hyle</u>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  | 22b. DATE THEREOF<br><u>10-10-56</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>to</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Emmaus, Pa</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>HOPPING FUNERAL HOME</u>  |  | 24a. REC'D BY REGISTRAR<br><u>DATE 15 1956</u>   |  |
| ADDRESS<br><u>ANNAPOLIS, MD.</u>   |  | 24b. REGISTRAR'S SIGNATURE   |  |

MEDICAL CERTIFICATION

3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. If burial, cremation, or removal, file pages 1 and 2 with the registrar.

BUREAU OF

OCT 15 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09991

10017

|   |                                  |  |  |   |  |   |   |
|---|----------------------------------|--|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>                       |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>2yr3mth15dys</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Glen Burnie, Maryland</u>  |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>SPRING GROVE STATE HOSPITAL</u>  |                                  |  |  | d. STREET ADDRESS<br><u>Bcx 1-Rt.1-Agushart Avenue</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Rosina Rose Rosie Diller</u>  |                                  |  |  | 4. DATE OF DEATH Month Day Year<br><u>October 2, 19 56</u>  |  |   |   |
| 5. SEX<br><u>female</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 8. DATE OF BIRTH<br><u>May 26, 1864</u>   |  | 9. AGE (In years last birthday)<br><u>92 yrs.</u>   | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br>—   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Germany</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |   |
| 13. FATHER'S NAME<br><u>Emil ?</u>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>unknown</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>unknown</u>  |  | 17. INFORMANT Address<br><u>Records: SPRING GROVE STATE HOSPITAL</u>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Fractured left hip</u> |                                  |  |  |   |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>to floor sustaining fractured left hip.</u> On 9-17-56 pt. fell |  |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>4:30 P. M.</u> <u>Sept. 17, 56</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Hospital</u>   |  | 20f. (City or town) (County) (State)<br><u>Catonsville, Maryland</u>                              |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .  |                                  |  |  |   |  |   |   |
| ACTUAL SIGNATURE<br><u>George M. Kieffer</u>  |                                  | EXAMINER'S NAME (Type)<br><u>George M. Kieffer, M. D.</u>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | DATE<br><u>10-2-56</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>Oct 4 1956</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Richle Heights</u> <u>MD</u>                  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Daniel Brothers</u>  |                                  |  |  | ADDRESS<br><u>1800 E Lombard Street</u>   |  | 24a. REC'D BY REGISTRAR<br><u>OCT 4 1956</u>  |   |
|   |                                  |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |   |

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained by your files. The funeral director, Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

BUREAU V. S.

1956 4 1

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09992

10018

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armancost Nursing Home</b>   |                                  | d. STREET ADDRESS <b>Wiltondale</b><br><b>309 Weatherbee Rd.</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SARAH</b> Middle <b>BERTHA</b> Last <b>DORSEY</b>  |                                  | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>5</b> Year <b>1956</b>   |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 13, 1888</b> |
| 9. AGE (In years last birthday)<br><b>67</b>   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Secretary</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Lumber</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>George Dorsey</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Florence Burgess</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>213-01-1827</b>   |  |
| 17. INFORMANT<br><b>Mrs. Charles A. Chow - 309 Weatherbee Rd.</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma (Generalized)</b><br><b>171X</b> DUE TO <b>Carcinoma of Cervix</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 yrs</b><br>(c) <b>6 months</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b><br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>June 1956</b> to <b>October 5, 1956</b> , that I last saw the deceased alive on <b>October 4, 1956</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>7501 York Rd. Baltimore, Md.</b> DATE SIGNED <b>10/5/56</b>   |                                  |   |  |
| ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>   |                                  | PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell MD</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>10/8/56</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Johns Cem.</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Ellicott City, Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Tidner &amp; Sons - Balto 17 Md</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>DATE October 6, 1956</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>R. W. Mason - m</b>   |                                  |   |  |

W. A. B. 1910

1910



## MEDICAL CERTIFICATION

VS A15 {4}  
15M 9/55

BUREAU V. S.

OCT 19 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

37

10020

|  |                                      |  |  |
|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Balto.</b> <b>MARYLAND</b>   |                                      | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <b>New York</b> b. COUNTY <b>17</b>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lutherville</b>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>New York City (formerly of)</b>                                   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>College Manor</b>   |                                      | d. STREET ADDRESS  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LEILA</b> Middle <b>THORNTON</b> Last <b>DUDLEY</b>  |                                      | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>17</b> Year <b>19 56</b>  |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 6, 1882</b>                                  |
| 9. AGE (In years last birthday)<br><b>74 yrs.</b>  |                                      | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.<br>Months Days Hours Min.                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Standard Oil Co.</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>   |                                      | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>Peter Dudley</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Mary Shaw</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                      | 16. SOCIAL SECURITY NO.<br><b>090-09-6602</b>  |  |
| 17. INFORMANT<br><b>Mr. Dudley H. Grape - 7303 Yorktown Drive</b>  |                                      | Address <b>Towson</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the stomach</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Cerebral Hemorrhage Hemiplegia</b> |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Nov. 19 55</b> to <b>Oct 17, 19 56</b> that I last saw the deceased alive on <b>Oct 16, 19 56</b> , and that death occurred at <b>12 P.M.</b> from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) DATE SIGNED   |                                      |  |  |
| ACTING SIGNATURE <b>William F. Pearce</b> M.D.   |                                      |  |  |
| PHYSICIAN'S NAME (Type) <b>WILLIAM F. PEARCE</b>   |                                      | <b>2105 N. Charles St.</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  | 22b. DATE THEREOF<br><b>10/19/56</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Spring Grove Cem.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Cincinnati, Ohio</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Lickner &amp; Sons - Balto. 17. Ind.</b>   |                                      | 24a. REC'D BY REGISTRAR<br><b>DATE 22 1956</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Ernest MacRae</b>   |                                      |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 10 1900

RECEIVED

10021

## CERTIFICATE OF DEATH

|   |                                  |   |   |   |  |   |  |
|---|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>  |                                  |   |   | c. LENGTH OF STAY IN 1b<br><b>24 Days</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Veterans Administration Hospital</b>   |                                  |   |   | d. STREET ADDRESS<br><b>114 Linhigh Avenue</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ERNEST</b> Middle Last <b>DURLING</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>1</b> Year <b>19 56</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>September 29, 1892</b> | 9. AGE (In years last birthday) yrs.<br><b>64</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min                               | IF UNDER 24 HRS<br>Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mechanic</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Air Craft</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Milford, Pennsylvania</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>John Durling</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Esther Silcox</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>WW-I</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>169-14-3245</b>   |   | 17. INFORMANT Address<br><b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>EMPHYEMA, RIGHT</b><br>DUE TO <b>ABSCCESS, RIGHT LOWER LOBE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO <b>INFARCTION, RIGHT LOWER LOBE</b><br>(c) <b>UNKNOWN</b>             |                                  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WEEK</b><br><b>UNKNOWN</b>                               |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Myocardial infarction due to arteriosclerotic coronary thrombosis duration unknown</b>  |                                  |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m.<br><b>19</b>  | Month<br><b>19</b>               | Day<br><b>19</b>  | Year<br><b>19</b>                             | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>September 7, 1956</b> , to <b>October 1, 1956</b> , and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Irving Freeman</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>10/2/56</b><br>SIGNATURE (Type) <b>IRVING FREEMAN, M.D.</b> |                                  |   |   |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Oct. 4, 1956</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore County, Maryland</b>                |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Lossahn Funeral Home, 7401 Belair Rd., Balto., Md.</b>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br><b>DATE 10 1956</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Newton L. Fair</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death Page 4

BUREAU V. P.

OCT. 9 1956

RECEIVED

10022

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Silver Spring Road</u>  |  | d. STREET ADDRESS <u>Silver Spring Road</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Mrs. Millie Berry Fink</u>   |  | 4. DATE OF DEATH <u>October 30st 19 56</u>   |  |
| 5. SEX <u>female</u>  | 6. COLOR OR RACE <u>white</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/15/1896</u>  |
| 9. AGE (In years last birthday) <u>60</u> yrs   |  | 10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Thomas C. Spurrier</u>   |  | 14. MOTHER'S MAIDEN NAME <u>?</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>   |  | 16. SOCIAL SECURITY NO. <u>  </u>  |  |
| 17. INFORMANT <u>Mr. John Adam Fink, Silver Spring Rd.</u>  |  | Address <u>  </u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma uteri</u><br>DUE TO (b) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>  </u><br>DUE TO (d) <u>  </u> |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>   | 20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>   | 20f. (City or town) (County) (State) <u>  </u>                           |
| 21. I certify that I attended the deceased from <u>June 1956</u> to <u>Oct 30, 1956</u> , that I last saw the deceased alive on <u>Oct 30, 1956</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.  |  |  |  |
| ACTUAL SIGNATURE <u>Dr. Richard R. Bieker</u> M.D.  |  | ADDRESS (Street, city or town, state) <u>1 L. Overles Ave. Balto. 6, Md.</u>   |  |
| PHYSICIAN'S NAME (Type) <u>Dr. Richard R. Bieker</u>  |  | DATE SIGNED <u>10-31-56</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>11/3/56</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>   | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>  |  | 24a. REC'D BY REGISTRAR <u>  </u>  | 24b. REGISTRAR'S SIGNATURE <u>Mrs. D. L. Heyneman</u>                    |

BUREAU V. B.

NOV 1 1956

RECEIVED



## 10023 CERTIFICATE OF DEATH

Reg. Dist. No.

30

|  |                                   |  |   |
|--|-----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel Co.</b>      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>  |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis, Maryland</b>  |   |
| c. LENGTH OF STAY IN 1b <b>2yr5mth2dys</b>   |                                   |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>  |                                   | d. STREET ADDRESS <b>Box 461 - Route #2</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Orilla</b> Middle <b>E.</b> Last <b>Firor</b>  |                                   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>16</b> Year <b>19 56</b>   |   |
| 5. SEX <b>female</b>   | 6. COLOR OR RACE <b>white</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Nov. 5, 1881</b>                                |
| 9. AGE (In years last birthday) <b>75 yrs.</b>   |                                   | IF UNDER 1 YEAR<br>Months Days Hours Min   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>  |   |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |                                   | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |   |
| 13. FATHER'S NAME <b>William Stansbury</b>   |                                   | 14. MOTHER'S MAIDEN NAME <b>Mary E. Bull</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no yes World War #1</b>   |                                   | 16. SOCIAL SECURITY NO. <b>unknown</b>   |   |
| 17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>  |                                   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b><br>DUE TO<br>(c) |                                   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. n. p. m. <b>19</b>   |                                   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>May 14, 1954</b> to <b>Oct. 16, 1956</b> that I last saw the deceased alive on <b>October 16, 1956</b> and that death occurred at <b>10:05 PM</b> , from the causes and on the date stated above.   |                                   |  |   |
| ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.   |                                   | ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>10-17-56</b>   |   |
| PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>  |                                   | <b>Catonsville 28, Maryland</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 22b. DATE THEREOF <b>10/20/56</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>London Park Cem.</b>   | 22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickner &amp; Sons - Baltimore</b>  |                                   | ADDRESS <b>Wm. J. Dickner &amp; Sons - Baltimore</b>   |   |
| 24a. REC'D BY REGISTRAR <b>DATE Oct. 18, 1956</b>  |                                   | 24b. REGISTRAR'S SIGNATURE <b>T. E. Harry</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. The funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 19 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09998

Reg. Dist. No.

38

|  |   |  |                                      |
|--|---|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Balto</u> <u>MARYLAND</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>                   |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>  |   | c. LENGTH OF STAY IN 1b <u>23 yrs.</u>   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2815 LINWOOD AVE</u>   |   | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (Parkville)</u>  |                                      |
| 3. NAME OF DECEASED (Type or print) <u>Leonhard</u> First <u>Fleischman</u> Middle <u>Lea</u> Last   |   | 4. DATE OF DEATH <u>October 8</u> Month <u>1956</u> Day <u>8</u> Year  |                                      |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>18 May 1887</u>  |
| 9. AGE (In years last birthday) <u>69</u> yrs.   |   | 10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST- CONT. CAN CO.</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>GERMANY</u>   |                                      |
| 11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA 1932</u>   |                                      |
| 13. FATHER'S NAME <u>Unknown</u>   |   | 14. MOTHER'S MAIDEN NAME <u>KATHERINE ITNER</u>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |   | 16. SOCIAL SECURITY NO. <u>215-03-3110</u>   |                                      |
| 17. INFORMANT <u>MRS Rosa Fleischmann</u>  |   | Address <u></u>  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>DUE TO <u>Atherosclerosis Generalized</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Undet</u>  |   | INTERVAL BETWEEN ONSET AND DEATH <u>Inst.</u>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma Chronic</u>  |   |  |                                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |   |  |                                      |
| SIGNATURE <u>John C. Hyle</u>  |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                      |
| EXAMINER'S NAME (Type) <u>JOHN C. HYLE</u>   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                      |
|  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                      |
| 22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>  |   | 22b. DATE THEREOF <u>10/10/56</u>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>   |   | 22d. LOCATION (City, town, or county) (State) <u>BALTO Md</u>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>  |   | 24a. REC'D BY REGISTRAR <u>DATE Oct. 10, 1956</u>  |                                      |
| ADDRESS <u>5545 Bayford</u>  |   | 24b. REGISTRAR'S SIGNATURE <u>Dr. L. M. Bacon</u>  |                                      |

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for removal, burial, cremation, or removal.

BUREAU V. S.

OUT

10/10/10

10025

# CERTIFICATE OF DEATH

Reg. Dist. No.

44

|  |                                    |   |   |   |   |   |                  |
|--|------------------------------------|---|---|---|---|---|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                    |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY |   |   |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>   |                                    | c. LENGTH OF STAY IN lb<br><b>8 Days</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>                        |   |   |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Veterans Administration Hospital</b>   |                                    |   |   | d. STREET ADDRESS<br><b>1620 Druid Hill Avenue</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>OTIS</b> Middle <b>FLEMING</b> Last   |                                    |   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>30</b> Year <b>19 56</b>  |   |   |                  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 16, 1892</b> |   | 9. AGE (In years at birthday) yrs <b>64</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Baker</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Confectionery</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Lancaster Co., Virginia</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                  |
| 13. FATHER'S NAME<br><b>Leonard B. Fleming</b>   |                                    |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Griffin</b>  |   |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b> <b>WW I</b>   |                                    | 16. SOCIAL SECURITY NO.<br><b>218-03-0394</b>   |   | 17. INFORMANT<br>Address<br><b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland</b>  |   |   |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>TUBERCULOSIS, PULMONARY, CHRONIC, FAR ADVANCED</b><br><b>002X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                    |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b>  |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b><br><b>VA</b>   |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |                  |
| 21. I certify that I attended the deceased from <b>October 22, 19 56</b> to <b>October 30, 19 56</b> , that I last saw the deceased <b>10:40 A.M.</b> and that death occurred at <b>10:40 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Francis S. Dickey</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>10/31/56</b>   |                                    |   |   |   |   |   |                  |
| ACTUAL SIGNATURE   |                                    | PHYSICIAN'S NAME (Type or print)<br><b>FRANCIS G. DICKEY, Chief, Medical Service, VAH, Fort Howard, Maryland</b>  |   |   |   |   |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                    | 22b. DATE THEREOF<br><b>Nov. 2, 1956</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem.</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                       |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles R. Law Mortuary</b>   |                                    |   |   | ADDRESS<br><b>802-04 Madison Ave.</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>11/3/56</b>  |                  |
|  |                                    |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Harrison L. Farber</b>   |   |   |                  |
| Baltimore 1. Md.   |                                    |   |   |   |   |   |                  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

U.S. AIR FORCE

NOV 7 1956

RECEIVED  
AIR FORCE

10026

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

|   |   |   |  |
|---|---|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)<br>c. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Dundalk, Maryland</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Dundalk</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>7524 Holabird Ave.</u>   |   | d. STREET ADDRESS<br><u>7524 Holabird Ave.</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>HOLDEN</u> Middle <u>CAMPBELL</u> Last <u>FORSYTHE</u>   |   | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>21</u> Year <u>1956</u>  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 8, 1908</u>                                   |
| 9. AGE (In years last birthday) yrs. <u>48</u>  |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Assistant Foreman</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Steel Mfr.</u>  | 11. BIRTHPLACE (State or foreign country)<br><u>West Virginia</u>          |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |   |  |
| 13. FATHER'S NAME<br><u>Samuel C. Forsythe</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Victoria Knox</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |   | 16. SOCIAL SECURITY NO.<br><u>705-10-6349</u>   | 17. INFORMANT<br><u>Robert D. Forsythe</u> Address <u>- same</u>           |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u><br>DUE TO (c) <u>—</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr.</u>                           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>19</u> p. m. <u>—</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that I attended the deceased from <u>10-19</u> , 19 <u>56</u> , to <u>10-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-21</u> , 19 <u>56</u> , and that death occurred at <u>7:45 P.</u> M. from the causes and on the date stated above.                               |   |   |  |
| ACTUAL SIGNATURE<br><u>Jack C. Collins</u>  |   | ADDRESS (Street, city or town, state) DATE SIGNED<br><u>2 Kent Ave. Baltimore 10-22-56</u>  |  |
| PHYSICIAN'S NAME (Type)<br><u>JACK C. COLLINS</u>   |   | <u>Baltimore 22</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 22b. DATE THEREOF<br><u>10-24-56</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Oak Lawn Cemetery</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Wm. B. Bradley</u>   |   | ADDRESS<br><u>Dundalk, Maryland</u>   |  |
| 24a. REC'D BY REGISTRAR<br><u>DATE 10-24-1956</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>James L. Harling</u>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 21 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the registrar. The registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 24 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10027 CERTIFICATE OF DEATH

10001  
Reg. Dist. No. 38

|  |                                  |   |  |   |  |   |  |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Balto.</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Stoneleigh</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>30 yrs.</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Stoneleigh</u>                               |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>6503 Maplewood Rd</u>   |                                  |   |  | d. STREET ADDRESS<br><u>6503 Maplewood Rd</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>ROBERT</u> Middle <u>E</u> Last <u>FOUTZ</u>   |                                  |   |  | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>23</u> Year <u>1956</u>   |  |   |  |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Feb. 5, 1877</u>   |  | 9. AGE (In years last birthday) <u>79</u> yrs.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Painter</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Business</u>  |  | 11. BIRTHPLACE (State of foreign country)<br><u>Johnsville, Frederick Co, Md</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>  |  |
| 13. FATHER'S NAME<br><u>Solomon S Foutz</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Naille</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>217-18-0677</u>   |  | 17. INFORMANT<br><u>Mrs Mary L Crawford Westminster Md</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Decompositional Cardio Vascular Disease</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u><br>DUE TO (c) |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. <u>11</u> p. m. 19 <u>56</u>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>Sept 1</u> 19 <u>56</u> , to <u>Oct 23</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 23</u> 19 <u>56</u> , and that death occurred at <u>7:40 PM</u> , from the causes and on the date stated above.  |                                  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Laurence C. Post</u>   |                                  |   |  | ADDRESS (Street, city or town, state) <u>6805 York Rd. Baltimore 12 Md.</u>   |  |   |  |
| PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>  |                                  |   |  | DATE SIGNED   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>Oct 25 1956</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Ebenezer</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Spinfeld Md</u>                               |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Henry W Jenkins Sons Co</u>   |                                  |   |  | ADDRESS<br><u>4905 York Rd</u>  |  |   |  |
| 24a. REC'D BY REGISTRAR<br><u>Oct 25 1956</u>  |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Malcolm</u>  |  |   |  |

BUREAU V. S.

OCT 9 1956

RECEIVED

10028

## CERTIFICATE OF DEATH

10002

Reg. Dist. No.

31

|  |                              |   |                                      |  |   |  |  |
|--|------------------------------|---|--------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>BALTIMORE</b> MARYLAND   |                              |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WOODLAWN</b>  |                              |   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WOODLAWN</b>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1749 LITTLE CREEK DR</b>  |                              |   |                                      | d. STREET ADDRESS<br><b>1749 LITTLE CREEK DR.</b>  |   |  |  |
| 3. NAME OF DECEASED (Type or print) <b>ALBERT B. FOX</b>   |                              |   |                                      | 4. DATE OF DEATH<br>Month <b>10</b> - Day <b>18</b> - Year <b>56</b>   |   |  |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-5-1908</b> | 9. AGE (In years last birthday)<br><b>48</b> yrs.  | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MEAT BUYER</b>   |                              |   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>EDDIES SUP. MKT</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>PHILADELPHIA</b>       |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                              |   |                                      |  |   |  |  |
| 13. FATHER'S NAME<br><b>JOSEPH FOX</b>   |                              |   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>IDA KLINE</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>NO</b>  |                                      | 17. INFORMANT<br><b>MARY E. FOX 1479 LITTLE CREEK</b>  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b><br>DUE TO <b>Carcinoma of colon</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>18 mos</b> |                              |   |                                      |  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |   |                                      |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              |   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                              |   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                    |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
|  |                              |   |                                      | 20f. (City or town)  |   | (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>April 27</b> , 19 <b>53</b> , to <b>Oct 18</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Oct 18</b> , 19 <b>56</b> , and that death occurred at <b>5 P. M.</b> , from the causes and on the date stated above.  |                              |   |                                      |  |   |  |  |
| ACTUAL SIGNATURE <b>Louis Blum, M.D.</b>   |                              |   |                                      | ADDRESS (Street, city or town, state) <b>2310 Guntan Place</b>   |   |  |  |
| PHYSICIAN'S NAME (Type) <b>Louis U. Blum</b>   |                              |   |                                      | DATE SIGNED <b>Baltimore, Md.</b>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>CREMATION</b>  |                              | 22b. DATE THEREOF<br><b>10/22/56</b>  |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>BALTO. MD</b>      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. T. STANSBURY</b>   |                              |   |                                      | 24a. REC'D BY REGISTRAR<br><b>6411 WINDSOR Mill</b>  |   |  |  |
|  |                              |   |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Oct 24 1956</b>   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

OCT 1 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10003

Reg. Dist. No.

10029

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>BALTIMORE</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u><br>c. LENGTH OF STAY IN It<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPARROWS POINT HOSPITAL</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u><br>d. STREET ADDRESS <u>401 EDSDALE ROAD</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>Gillespie, Jesse</u> First <u>BOYD</u> Middle <u>Gillespie</u> Last<br><b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>APR. 13, 1906</u><br><b>9. AGE</b> (In yrs. last birthday) <u>40</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.        |  | <b>4. DATE OF DEATH</b> Month <u>10</u> Day <u>27</u> Year <u>1956</u><br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Mechanical Maintenance</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Steel Mfg.</u><br><b>11. BIRTHPLACE</b> (State or foreign country) <u>Henry Co., Va.</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u> |  |
| <b>13. FATHER'S NAME</b> <u>Thomas I. Gillespie</u><br><b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NONE</u> (If yes, give war or dates of service)<br><b>16. SOCIAL SECURITY NO.</b> <u>242-05-1663</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Belle Davis</u><br><b>17. INFORMANT</b> Address <u>Mrs. Edith R. Gillespie-401 Edsdale Rd., Balto.</u>   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. DUE TO (c)  |  | INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>19</u> o. m. p. m.  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)   |  |
| <b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . |  |   |  |
| <b>ACTUAL SIGNATURE</b> <u>Jack C. Collins</u><br><b>EXAMINER'S NAME (Type)</b> <u>Jack C. Collins</u>   |  | <b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u><br><b>22b. DATE THEREOF</b> <u>OCT. 30, 1956</u><br><b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>SHERWOOD CEMETERY</u><br><b>22d. LOCATION (City, town, or county)</b> (State) <u>ROANOKE, VIRGINIA</u>   |  | <b>24a. REC'D BY REGISTRAR</b> <u>DATE 29 1956</u><br><b>24b. REGISTRAR'S SIGNATURE</b> <u>James A. Harvey</u>  |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>WM. J. TACKNER AND SONS, BALTIMORE, MD.</u><br><u>Wm. J. Tackner &amp; Sons</u>   |  |   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained by your files. The funeral director should file pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

RECEIVED

10030

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |  |  |
|---|---|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Essex</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>White Marsh</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Ivy Hill Nurring Home</b>  |   | d. STREET ADDRESS  |  |
| 3 NAME OF DECEASED<br>(Type or print) <b>Elizabeth First Ann Gladfelter Last</b>  |   | 4. DATE OF DEATH<br><b>Oct 10</b> Year <b>1956</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 23, 1868</b>                                  |
| 9. AGE (In years last birthday) <b>88</b> yrs.  |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>               |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 13. FATHER'S NAME<br><b>William Talbott</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Susan Daily</b>  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>                          |  |
| 16. SOCIAL SECURITY NO. <b>None</b>   |   | 17. INFORMANT <b>Family records</b> Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular disease</b><br>DUE TO (c) <b>2 yrs</b> |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>                          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                       |
| 21. I certify that I attended the deceased from <b>Oct 8, 1956</b> to <b>Oct 10, 1956</b> that I last saw the deceased alive on <b>Oct 9, 1956</b> , and that death occurred at <b>5:30 A. M.</b> from the causes and on the date stated above.   |   |  |  |
| ACTUAL SIGNATURE <b>J. M. [Signature]</b> M.D.  |   | ADDRESS (Street, city or town, state) <b>Balto 6 Md</b> DATE SIGNED <b>10/10/56</b>  |  |
| PHYSICIAN'S NAME (Type)   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>Oct. 13, 1956</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Luthern Cemetery,</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Shrewsbury, Penna.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>[Signature]</b>  |   | ADDRESS<br><b>Towson, Maryland</b>   | 24a. REC'D BY REGISTRAR<br><b>DATE 10-15-1956</b>                          |
|   |   | 24b. REGISTRAR'S SIGNATURE   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be relayed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

OCT 5 1956

RECEIVED



10031

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

|   |                           |  |                                    |
|---|---------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTO.</u> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>                       |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>   |                           | c. LENGTH OF STAY IN 1b <u>40 yr</u>   |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>611 Harlem Ave</u>  |                           | d. STREET ADDRESS <u>same</u>  |                                    |
| 3. NAME OF DECEASED (Type or print) <u>Gertrude M. Glanville</u>  |                           | 4. DATE OF DEATH <u>Oct. 23</u> 19 <u>56</u>   |                                    |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/28/1838</u> |
| 9. AGE (In years last birthday) <u>67</u> yrs   |                           | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>   |                                    |
| 11. BIRTHPLACE (State or foreign country) <u>MD.</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                    |
| 13. FATHER'S NAME <u>John DeGraff</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Parker</u>   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                           | 16. SOCIAL SECURITY NO. <u>Mr. Gertrude Skipton</u>  |                                    |
| 17. INFORMANT <u>Mr. Gertrude Skipton</u>   |                           | Address  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE UTERUS</u> 3<br><u>174X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(OPERATION AND METASTASES)</u><br>DUE TO (c) |                           |  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>  |                           |  |                                    |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |  |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>0</u>  |                                    |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>0</u> <u>19</u>  |                           | 20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that I attended the deceased from <u>AUG. 18</u> , 19 <u>53</u> , to <u>OCT. 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>OCT. 19</u> , 19 <u>56</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.  |                           |  |                                    |
| ACTUAL SIGNATURE <u>S. Lloyd Johnson</u> M.D.   |                           | DATE SIGNED <u>6348 FREDERICK ROAD</u>   |                                    |
| PHYSICIAN'S NAME (Type) <u>S. LLOYD JOHNSON, M.D.</u>   |                           | <u>6348 FREDERICK ROAD, CATONSVILLE, MD.</u>   |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 22b. DATE THEREOF <u>10/23/56</u>  |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>  |                           | 22d. LOCATION (City, town, or county) (State) <u>Balto Co</u>  |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>M. W. Johnson</u>   |                           | ADDRESS <u>28</u>  |                                    |
| 24a. REC'D BY REGISTRAR   |                           | 24b. REGISTRAR'S SIGNATURE <u>J. H. Harris</u>   |                                    |
| DATE <u>12/24/56</u>  |                           |  |                                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, who should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JOHN A. Y. Z.

1956

1956

## 10032 CERTIFICATE OF DEATH

Reg. Dist. No.

10006

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR and give nearest town)  
 TOWN Rural: Towson  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS  
Eudowood Sanatorium  
Towson 4, Maryland

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Lutherville  
 STREET ADDRESS (If rural give location)  
504 Spring Avenue

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

HARTWELLD.GLASS

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

October 25, 1956

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

MALE WHITEMARRIED12-25-2629 yrs.

Months Days Hours Min.

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

ENGINEERMECHANICAL ENGINEER VirginiaU.S.A.

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

JAMES B. GLASSANNA RICHARDS

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.:

## 17. INFORMANT &amp; ADDRESS: Personal History Hospital Records, Eudowood Sanatorium

YESWorld War II231-24-6461

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

DUE TO

## Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

7/26/56Lymph nodes showed

## 20. AUTOPSY?

Yes ☒ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-25-56 to 10/25-56, that I last saw the deceased alive on 10/25-56, and that death occurred at 5:00 PM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Milton B. KussEudowood Sanatorium - Towson 4, Maryland

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

RemovalOct. 26, 1956John M. Oakeys Funeral HomeRoanoke, Virginia

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

Oct. 26, 1956Mabel C. GrayJohn Barnes' SonsTowson, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REAU V. S.

1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10007

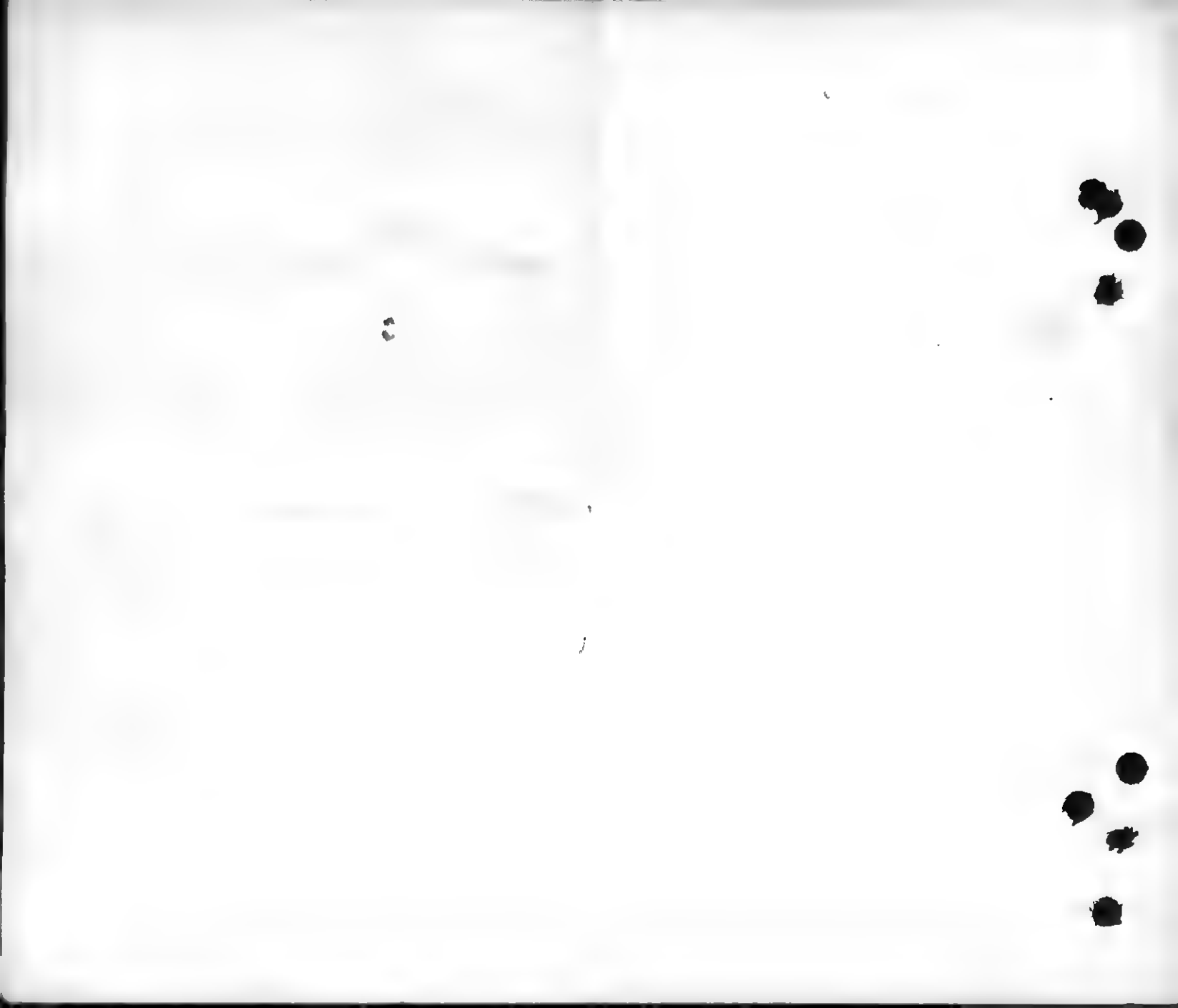
## 10033 CERTIFICATE OF DEATH

Reg. Dist. No. ....

|   |                              |  |   |
|---|------------------------------|--|---|
| 1. PLACE OF DEATH<br>COUNTY <u>Baltimore County</u> MARYLAND  |                              | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Maryland</u> COUNTY <u>Baltimore</u>   |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Rural - Baltimore</u> LENGTH OF STAY (in this place) <u>11 yrs</u>   |                              | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Rural - Baltimore</u>   |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7400 Belmont Avenue</u>  |                              | STREET ADDRESS (If rural give location) <u>7400 Belmont Ave</u>  |   |
| 3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>A.</u> (Last) <u>Goldys</u>   |                              | 4. DATE OF DEATH (Month) <u>October</u> (Day) <u>21</u> (Year) <u>1956</u>   |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>W.H.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>   | 8. DATE OF BIRTH <u>3/12/1872</u>                       |
| 9. AGE last birthday <u>84</u> yrs.   |                              | If under 1 year (Months) (Days) (Hours) (Min.)   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Still Operator</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY <u>J. S. Young Co.</u>   | 11. BIRTHPLACE (state or foreign country) <u>Poland</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>Poland</u>   |                              | 13. FATHER'S NAME <u>John Andrew Goldys</u>  |   |
| 14. MOTHER'S MAIDEN NAME <u>Sophia</u>  |                              | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |   |
| 16. SOCIAL SECURITY No. <u>212-10-0983</u>  |                              | 17. INFORMANT <u>Mary Goldys 7400 Belmont Ave</u>  |   |
| 18. MEDICAL CERTIFICATION   |                              |  |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                              |  | INTERVAL BETWEEN ONSET AND DEATH                        |
| 4 Immediate cause (a) <u>Cerebral Vascular Accidents</u>  |                              |  | <u>7 days</u>   |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arteriosclerotic cardiovascular disease</u>   |                              |  | <u>&gt; 10 yrs.</u>                                     |
| (c)   |                              |  |   |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  |                              |  |   |
| 19a. DATE OF OPERATION  |                              | 19b. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |                              |  |   |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE   |                              | PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)  |   |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |                              | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?                                |   |
| 22. I hereby certify that I attended the deceased from <u>did not</u> , 19....., to <u>never</u> , 19....., that I last saw the deceased alive on <u>4 A</u> , 19....., and that death occurred at <u>4 A</u> m., from the causes and on the date stated above. |                              |  |   |
| SIGNATURE <u>Laurel C. Levy M.D.</u> (Degree or title)  |                              | ADDRESS <u>434 Eastern Ave. Essex Md</u> DATE SIGNED <u>10/21/56</u>   |   |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>   |                              | DATE THEREOF <u>10/24/56</u> NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Jesus</u> LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u> |   |
| DATE REC'D BY LOCAL REG.  |                              | REGISTRAR'S SIGNATURE <u>Wm. J. Kowalski</u> ADDRESS <u>2067 Eastern Ave</u>   |   |

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10008

Reg. Dist. No. 23

|   |   |  |   |
|---|---|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u> <span style="float: right;">10034</span><br>MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Owings Mills</u><br>c. LENGTH OF STAY IN 1b<br><u>Visiting</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Lyons Mill Road</u>  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Pikesville</u><br>d. STREET ADDRESS<br><u>South Road</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First Middle Last<br><u>CLINTON LYNCH GOODWIN</u>   |   | <b>4. DATE OF DEATH</b><br>Month Day Year<br><u>OCT. 15, 1956</u>  |   |
| <b>5. SEX</b><br><u>MALE</u>  | <b>6. COLOR OR RACE</b><br><u>WHITE</u> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br><u>August 25, 1888</u> |
| <b>9. AGE</b> (In years last birthday)<br><u>68</u> yrs   |   | <b>10. IF UNDER 1 YEAR</b><br>Months Days Hours Min.<br>IF UNDER 24 HRS.   |   |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Veterinarian</u>   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Veterinary</u>  |   |
| <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Baltimore, Maryland</u>  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>   |   |
| <b>13. FATHER'S NAME</b><br><u>Franklin P. Goodwin</u>  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Unknown Josephine Bosley</u>   |   |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)<br><u>Yes</u> <u>W.W.#1</u>   |   | <b>16. SOCIAL SECURITY NO.</b><br><u>220-34-7320</u>   |   |
| <b>17. INFORMANT</b><br><u>Francis Goodwin (Wife)</u>   |   | <b>Address</b><br><u>Pikesville, Md</u>  |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>DUE TO<br>(c) _____   |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>none</u>  |   |  |   |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>20 min.</u>  |   |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.</b><br><u>none</u>  |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)<br><u>none</u>  |   |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a. m. p. m.<br><u>none 19</u>  |   | <b>20d. INJURY OCCURRED</b><br>While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>  |   |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><u>none</u>  |   | <b>20f. (City or town) (County) (State)</b><br><u>none</u>   |   |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b><br>Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> |   |  |   |
| <b>ACTUAL SIGNATURE</b><br><u>D. D. Caples</u>  |   | <b>DATE SIGNED</b><br><u>10-17-56</u>  |   |
| <b>EXAMINER'S NAME (Type)</b><br><u>D. D. Caples, M. D.</u>   |   | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>  |   |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>   |   | <b>22b. DATE THEREOF</b><br><u>10-18, 56</u>   |   |
| <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Druid Ridge</u>   |   | <b>22d. LOCATION (City, town, or county) (State)</b><br><u>Pikesville, Md.</u>   |   |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Frank H. Newell - Pikesville 8, Md.</u>   |   | <b>24a. REC'D BY REGISTRAR</b><br><u>DATE</u>  |   |
| <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Mary Elise</u>  |   | <b>24c. REGISTRAR'S SIGNATURE</b><br><u>Mary Elise</u>   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.

RECEIVED

OCT 19 1956

BUREAU V. S.



Reg. Dist. No. **10009**

10035

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Parkville</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>2904 Hillcrest Avenue</u>  |                                  | d. STREET ADDRESS<br><u>743 Linnard Street</u>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Mrs. Agnes Estella Gourley</u>  |                                  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>2nd</u> Year <u>19 56</u>   |   |
| 5. SEX<br><u>female</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 19, 1883</u> |
| 9. AGE (in years last birthday)<br><u>73</u> yrs.   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Maryland</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>George Nicholson</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Timmins</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><u>Mrs. Mary Kram, 2904 Hillcrest Avenue #14</u>   |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br>DUE TO <u>Pancreatic Carcinoma</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Pancreatic Carcinoma</u><br>DUE TO<br>(c) <u>Malnutrition and Paralytic illness</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition and Paralytic illness</u> |                                  |   |   |
| INTERVAL BETWEEN ONSET AND DEATH  |                                  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>10-2</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>10-1</u> , 19 <u>56</u> , and that death occurred at <u>3:06</u> M., from the causes and on the date stated above.  |                                  |   |   |
| ACTUAL SIGNATURE<br><u>John C. Hyle</u>   |                                  | ADDRESS (Street, city or town, state)<br><u>7527 Belair Rd</u>  |   |
| DATE SIGNED<br><u>10-2-56</u>   |                                  |   |   |
| PHYSICIAN'S NAME (Type)<br><u>JOHN C. HYLE</u>  |                                  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>10/5/56</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>New Cathedral Cem.</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Leonard J. Ruck 5305 Hargord Road #14</u>  |                                  | ADDRESS<br><u>5305 Hargord Road #14</u>   |   |
| 24a. REC'D BY REGISTRAR<br><u>DATE 5 1956</u>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>10-2-56</u>  |   |

BUREAU V. 2

OF 5 1956

RECEIVED

1

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

10010

Reg. Dist. No. ....

10036

|  |                           |  |                                      |   |                              |  |                  |
|--|---------------------------|--|--------------------------------------|---|------------------------------|--|------------------|
| 1. PLACE OF DEATH  |                           |  |                                      | 2. USUAL RESIDENCE (HOME) OF DECEASED   |                              |  |                  |
| COUNTY <u>BALTIMORE</u>  |                           | STATE <u>MARYLAND</u>  |                                      | STATE <u>MD</u> COUNTY <u>BALTO</u>   |                              |  |                  |
| CITY (If outside corporate limits, write RURAL and give nearest town)  |                           | LENGTH OF STAY (in this place)   |                                      | CITY (If outside corporate limits, write RURAL and give nearest town)             |                              |  |                  |
| TOWN   |                           | <u>8 YEARS</u>   |                                      | TOWN <u>ROSEDALE</u>  |                              |  |                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1538 ROSEWICK AVE</u>   |                           |  |                                      | STREET ADDRESS (If rural give location) <u>1538 ROSEWICK AVE</u>                  |                              |  |                  |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY E BRANVILLE</u>  |                           |  |                                      | 4. DATE OF DEATH (Month) (Day) (Year) <u>10/30/56</u>                             |                              |  |                  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>  | 8. DATE OF BIRTH <u>NOV 13, 1876</u> | 9. AGE last birthday <u>79</u> yrs.   | IF UNDER 1 YEAR              |  | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>   |                           |  | 10b. KIND OF BUSINESS OR INDUSTRY    | 11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>                        | 12. CITIZEN OF WHAT COUNTRY? |  |                  |
| 13. FATHER'S NAME <u>LAWRENCE KNOBEL</u>   |                           |  |                                      | 14. MOTHER'S MAIDEN NAME <u>CATHERINE LETCHER</u>                                 |                              |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |                           |  |                                      | 16. SOCIAL SECURITY NO.   |                              | 17. INFORMANT & ADDRESS <u>1538 ROSEWICK ELIZABETH SCHMAELZLE AVE</u>            |                  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                           |  |                                      |   |                              | INTERVAL BETWEEN ONSET AND DEATH   |                  |
| IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>  |                           |  |                                      |   |                              | 30 minutes   |                  |
| ANTECEDENT CAUSE(S) DUE TO <u>Arteriosclerotic Heart Disease</u>   |                           |  |                                      |   |                              | 10 years   |                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)   |                           |  |                                      |   |                              |  |                  |
| DUE TO (C)   |                           |  |                                      |   |                              |  |                  |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                           |  |                                      |   |                              |  |                  |
| 19a. DATE OF OPERATION   |                           | 19b. MAJOR FINDINGS OF OPERATION   |                                      |   |                              | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |                                      | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                      |                              |  |                  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |                           | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                      | 21f. HOW DID INJURY OCCUR?  |                              |  |                  |
| 22. I hereby certify that I attended the deceased from <u>Jan. 1954</u> to <u>Oct. 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 30</u> , 19 <u>56</u> , and that death occurred at <u>8:55a</u> M., from the causes and on the date stated above. |                           |  |                                      |   |                              |  |                  |
| SIGNATURE <u>John R. Mann, M.D.</u>  |                           |  |                                      | ADDRESS (Street, city, town, state) <u>8019 Philadelphia Rd. Baltimore 6, Md.</u> |                              | DATE SIGNED  |                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>   |                           | DATE THEREOF <u>11/2/56</u>  |                                      | NAME OF CEMETERY OR CREMATORY <u>ZION EVANG. CENT</u>                             |                              | LOCATION (City, town, or county) (State) <u>STEMMERS RUN. MD</u>                 |                  |
| 24. REC'D BY REGISTRAR <u>Edith Shuley</u>   |                           | REGISTRAR'S SIGNATURE  |                                      | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Flaunce F. Hoffman</u>                        |                              | ADDRESS <u>5218 Hudson St</u>  |                  |
| DATE   |                           |  |                                      |   |                              |  |                  |

BUREAU V. 2

1912

RECEIVED

10037

CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>   |  |   |  | c. LENGTH OF STAY IN 1b  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Veterans Administration Hospital</b>   |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Edgewater, Maryland</b>   |  |   |  |
| f. STREET ADDRESS<br><b>Rt.#1 Box 442 A</b>  |  |   |  | • IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JAMES</b> Middle <b>A.</b> Last <b>GREEN</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>11</b> Year <b>1956</b>  |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Colored</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 8. DATE OF BIRTH<br><b>July 4, 1887</b>                                     |  |
| 9. AGE (In years last birthday) yrs.<br><b>69</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer unemployed</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                             |  |
| 13. FATHER'S NAME<br><b>John Green</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Harriett Jilling</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>Yes</b>  |  |   |  | 16. LOCAL SECURITY NO.<br><b>243-22-0418</b>   |  |   |  |
| 17. INFORMANT<br><b>Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>  |  |   |  | Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br><b>LXXX</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE- Duration Unknown</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)      |  |
| 20f. (City or town) _____ (County) _____ (State) _____   |  |   |  | 20g. (City or town) _____ (County) _____ (State) _____   |  |   |  |
| 21. I certify that I attended the deceased from <b>October 5, 1956</b> , to <b>October 11, 1956</b> , and that death occurred at <b>12:50 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED _____<br>ACTUAL SIGNATURE <b>Francis G. Dickey</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>10/11/56</b><br>PHYSICIAN'S NAME (Type) <b>FRANCIS G. DICKEY, Chief Medical Service</b>   |  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>10-15-56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Annapolis National</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Annapolis, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Reese, 108 Washington St., Annapolis, Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>DATE 10-11-56</b>  |  | 24b. REGISTRAR'S SIGNATURE  |  |

8140-52 618

BUREAU V. B.

1956

RECEIVED

10-12-56

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10038

CERTIFICATE OF DEATH

Reg. Dist. No.

1001240

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KINGSVILLE</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KINGSVILLE</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CHAPMAN ROAD</b>  |  | d. STREET ADDRESS <b>CHAPMAN RD.</b>   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>HARRY C GRIFFIN</b>  |  | 4. DATE OF DEATH Month Day Year <b>OCT. 19 1956</b>  |  |
| 5. SEX <b>MALE</b>  | 6. COLOR OR RACE <b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>NOV. 13-1893</b>   |
| 9. AGE (In years last birthday) <b>63 yrs</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARBER</b>   | 11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>                                    |
| 12. CITIZEN OF WHAT COUNTRY?  |  | 13. FATHER'S NAME <b>HARRY GRIFFIN</b>   |  |
| 14. MOTHER'S MAIDEN NAME <b>ALMIRE DREBEN</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |
| 16. SOCIAL SECURITY NO. <b>215-32-0143</b>  |  | 17. INFORMANT Address <b>ANNA GRIFFIN ABOVE</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>26 yrs</b><br>(b) <b>Arteriosclerotic Cardiovascular disease</b><br>DUE TO<br>(c) <b>20 yrs.</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 yrs.</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>Oct. 19, 1956</b> , to <b>Oct. 19, 1956</b> , that I last saw the deceased alive on <b>Oct. 19, 1956</b> , and that death occurred at <b>2:58 M.</b> from the causes and on the date stated above  |  |  |  |
| ACTUAL SIGNATURE <b>William A. Tyson</b> M.D.   |  | ADDRESS (Street, city or town, state) <b>Kingsville, Md.</b> DATE SIGNED <b>10-20-56</b>   |  |
| PHYSICIAN'S NAME (Type) <b>William A. Tyson</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   | 22b. DATE THEREOF <b>OCT. 22-56</b>  | 22c. NAME OF CEMETERY OR CREMATORY <b>MORELAND PARK</b>  | 22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Connelly</b> ADDRESS <b>418 Eastern Ave., East 21-Md.</b>   |  | 24a. REC'D BY REGISTRAR DATE <b>10-24-1956</b> 24b. REGISTRAR'S SIGNATURE <b>Dr. Walter Hammett</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 14 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 10 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10013

Reg. Dist. No. 20

10039

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Baltimore</b> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b><br>c. LENGTH OF STAY IN 1b <b>19yrs2mt26dys</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine, Maryland</b><br>d. STREET ADDRESS <b>Woodbine, Maryland</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) First Middle Last<br><b>John Grimes</b>  |  |  |  | <b>4. DATE OF DEATH</b> Month Day Year<br><b>October 24, 19 56</b>  |  |   |  |
| <b>5. SEX</b><br><b>male</b>  |  | <b>6. COLOR OR RACE</b><br><b>white</b>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><b>unknown</b>   |  |
| <b>9. AGE</b> (In years last birthday) <b>71?</b> yrs.  |  | <b>IF UNDER 1 YEAR</b><br>Months Days Hours Min.   |  | <b>IF UNDER 24 HRS.</b><br>Hours Min.   |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>farmer</b> |  |
| <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>farming</b>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Maryland</b>                      |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U. S. A.</b>  |  | <b>13. FATHER'S NAME</b><br><b>unknown</b>  |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><b>unknown</b>   |  | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>unknown</b> |  | <b>16. SOCIAL SECURITY NO.</b><br><b>unknown</b>  |  | <b>17. INFORMANT</b> Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO <b>Hypertensive Cerebrovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)   |  |  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dietetic Mele.</b>   |  |  |  |   |  |   |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>Accidental death</b>   |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br><b>6:30 AM 10-24-56</b>  |  |  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>Extensive 28, Maryland</b>      |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> |  |  |  |   |  |   |  |
| <b>ACTUAL SIGNATURE</b> <b>George M. Kieffer</b> M.D.   |  |  |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>  |  |   |  |
| <b>EXAMINER'S NAME (Type)</b> <b>George M. Kieffer, M. D.</b>   |  |  |  | <b>DATE SIGNED</b> <b>10-24-56</b>  |  |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>   |  | <b>22b. DATE THEREOF</b><br><b>10-25-56</b>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Jennings Chapel</b>   |  | <b>22d. LOCATION (City, town, or county) (State)</b><br><b>Florence, Md</b>   |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS<br><b>F. C. Higinbotham, Ellicott City, Md</b>  |  |  |  | <b>24a. REC'D BY REGISTRAR</b>  |  | <b>24b. REGISTRAR'S SIGNATURE</b><br><b>6. Harnes</b>   |  |

THIS DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.

DUREAU V. S.

1956

CT

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

Reg. Dist. No. 33

|  |                 |   |  |   |  |       |     |   |  |  |  |
|--|-----------------|---|--|---|--|-------|-----|---|--|--|--|
| <b>1 PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u><br>c. LENGTH OF STAY IN 1b <u>4 Days</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>  |                 |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Westminster</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u><br>d. STREET ADDRESS <u>582 W. Balto. Blvd.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |       |     |   |  |  |  |
| <b>3 NAME OF DECEASED</b><br>(Type or print) <u>PAUL T. GROVE</u>  |                 |   | <b>4. DATE OF DEATH</b><br>Month <u>October</u> Day <u>20</u> Year <u>1956</u> |   |  |       |     |   |  |  |  |
| <b>5. SEX</b><br><u>Male</u>   |                 | <b>6. COLOR OR RACE</b><br><u>White</u>   |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b><br><u>10/20/93</u>   |  |       |     |   |  |  |  |
| <b>9. AGE</b> (In years last birthday) <u>63</u> yrs <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min</td> </tr> </table>   |                 | IF UNDER 1 YEAR   | IF UNDER 24 HRS  | Months  | Days   | Hours | Min | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Creamery Company</u> |  | <b>11 BIRTHPLACE</b> (State or foreign country) <u>Atlantic, Iowa</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u> |  |
| IF UNDER 1 YEAR  | IF UNDER 24 HRS |   |  |   |  |       |     |   |  |  |  |
| Months   | Days            |   |  |   |  |       |     |   |  |  |  |
| Hours  | Min             |   |  |   |  |       |     |   |  |  |  |
| <b>13 FATHER'S NAME</b><br><u>John E. Grove</u>  |                 |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Dora Hodges</u>                          |   |  |       |     |   |  |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no or unknown) <u>Yes</u> <u>WW-I</u>   |                 | <b>16. SOCIAL SECURITY NO.</b><br><u>Unknown</u>  |  | <b>17. INFORMANT</b><br><u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</u>   |  |       |     |   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL FAILURE</u><br>DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE AURICULAR AND VENTRICULAR FIBRILLATION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UNDIFFERENTIATED BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE BRONCHUS WITH METASTASIS TO VERTEBRAE</u> |                 |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>SUDDEN</u><br><u>UNDETERMINED</u> |       |     |   |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                 |   |  |   |  |       |     |   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b><br>(If either, NOTIFY MEDICAL EXAMINER)   |                 | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |       |     |   |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a. m. _____ p. m. <u>19</u>   |                 | <b>20d. INJURY OCCURRED</b><br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)  |  |       |     |   |  |  |  |
| <b>21. I certify that</b> <u>VA</u> <b>attended the deceased from</b> <u>October 15, 1956</u> , <b>to</b> <u>October 19, 1956</u> <b>that death occurred at</b> _____ <b>M, from the causes and on the date stated above.</b><br><b>ADDRESS</b> (Street, city or town, state) <u>VAH, Fort Howard, Maryland</u> <b>DATE SIGNED</b> <u>10/20/56</u>   |                 |   |  |   |  |       |     |   |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>Rolando P. Ponce de Leon</u> <b>M.D.</b> <u>VAH, Fort Howard, Maryland</u>  |                 |   |  |   |  |       |     |   |  |  |  |
| <b>PHYSICIAN'S NAME (Type)</b> <u>ROLANDO D. PONCE DE LEON</u> <u>VAH, Fort Howard, Maryland</u>   |                 |   |  |   |  |       |     |   |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  |                 | <b>22b. DATE THEREOF</b><br><u>10/23/56</u>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Westminster Cemetery</u>  |  |       |     |   |  |  |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Harvey Bankart &amp; Sons Funeral Home</u><br><u>Main Street Westminster, Maryland</u>   |                 | <b>24a. REC'D BY REGISTRAR</b><br><u>DATE 10/20-56</u>  |  | <b>24b. REGISTRAR'S SIGNATURE</b><br><u>[Signature]</u>   |  |       |     |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4- may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 and file with the registrar proper burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 20 1950

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

30

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> <b>10041</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home-Harlem Lane</b>  |  |   |  | 2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY <b>1</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City (12)</b><br>d. STREET ADDRESS <b>212 W. Lafayette Avenue</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>JENNIE</b> Middle <b>WILHEMINA</b> Last <b>HAMBRAUCH</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>27,</b> Year <b>1956</b>   |  |   |  |
| 5. SEX <b>female</b>   |  | 6. COLOR OR RACE <b>white</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>June 23, 1906</b>   |  |
| 9. AGE (In years last birthday) <b>50 yrs</b>  |  | IF UNDER 1 YEAR<br>Months <b>50</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>                             |  | IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME <b>William Sauble</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Jennie Little</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>None</b> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <b>none</b>   |  | 17. INFORMANT <b>Mrs. Viola Kendall - 2300 E. Fayette St.</b> Address   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General debility secondary to Cancer of the ovary</b><br>DUE TO (c) <b>to Cancer of the ovary</b> |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>5 months</b><br><b>9 months</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month. <b>19</b> Day. <b>19</b> Year. <b>19</b><br>Hour a. m. <b>19</b> p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>June 1952</b> to <b>OCT 27, 1952</b> , that I last saw the deceased alive on <b>OCT 26, 1952</b> , and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>4605 Edmondson Ave</b> DATE SIGNED <b>1952</b>                                   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Cliff Ratliff, Jr.</b> M.D.  |  | PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF, JR.</b> <b>4605 EDMONDSON AVE.</b>                              |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>10/31/56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Branch Cem.</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Westminster, Md.</b>                   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto 17, Md.</b> ADDRESS <b>Balto 17, Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR <b>10/1, 1956</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>W. E. Harry</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar. Pages 1 and 2 should be filed with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please receive carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 2 1956

BUREAU V. S.

1

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE A15C 1-10M-

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 Film 206 11-2-56 et

## CERTIFICATE OF DEATH

10016

Reg. Dist. No. .... in ..

10042

|  |                                  |  |   |  |                                |  |  |
|--|----------------------------------|--|---|--|--------------------------------|--|--|
| 1. PLACE OF DEATH  |                                  |  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                                |  |  |
| COUNTY <u>Baltimore</u>  |                                  | MARYLAND   |   | STATE <u>Md.</u>   |                                | COUNTY <u>Baltimore</u>  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Sparrows Point</u>  |                                  | LENGTH OF STAY (in this place)<br><u>26 years</u>  |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Sparrows Point Md.</u> |                                |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 311 Penwood Ave</u>   |                                  |  |   | STREET ADDRESS (If rural give location)<br><u>Box 311 Penwood Ave.</u>                                     |                                |  |  |
| 3. NAME OF DECEASED (Type or Print) <u>George Ellwood Hammond</u>  |                                  |  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Oct 24 1956</u>  |                                |  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>Married</u>                                     | 8. DATE OF BIRTH<br><u>Nov. 26-1889</u> | 9. AGE last birthday<br><u>67</u> yrs.   | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Roll-setter</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Bellevue Steel Co.</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>Middletown-Penna.</u>                                      |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                            |  |
| 13. FATHER'S NAME<br><u>Elmer Ellsworth Hammond</u>  |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Anna M. Cain</u>  |                                |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>213-07-8479</u>  |   | 17. INFORMANT & ADDRESS<br><u>Bertha B. Hammond Box 311 Penwood Ave</u>                                    |                                |  |  |
| 18. MEDICAL CERTIFICATION  |                                  |  |   |  |                                | INTERVAL BETWEEN ONSET AND DEATH   |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                  |  |   |  |                                |  |  |
| IMMEDIATE CAUSE (A) <u>Heart Failure</u>   |                                  |  |   |  |                                | <u>5 days</u>  |  |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic obstructive heart disease</u>  |                                  |  |   |  |                                | <u>10 years</u>  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)   |                                  |  |   |  |                                |  |  |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                                  |  |   |  |                                |  |  |
| 19a. DATE OF OPERATION   |                                  | 19b. MAJOR FINDINGS OF OPERATION   |   |  |                                | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                                  | 21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)                                 |   | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |                                |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)   |                                  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?   |                                |  |  |
| 22. I hereby certify that I attended the deceased from <u>Jan 1, 1956</u> to <u>Oct 24, 56</u> , that I last saw the deceased alive on <u>Oct 23, 1956</u> , and that death occurred at <u>6:55 PM</u> , from the causes and on the date stated above. |                                  |  |   |  |                                |  |  |
| SIGNATURE <u>[Signature]</u>   |                                  | M.D. <u>520 1st St. Spt. 17 Md. 102516</u>   |   | DATE SIGNED <u>10/25/56</u>  |                                |  |  |
| 23. BURIAL, CREMATION REMOVAL (Specify)<br><u>Burial</u>   |                                  | DATE THEREOF<br><u>10/27/56</u>  |   | NAME OF CEMETERY OR CREMATORY<br><u>Glenn Haven</u>  |                                | LOCATION (City, town, or county) (State)<br><u>Balto Md.</u>             |  |
| 24. REC'D BY REGISTRAR<br>DATE <u>10-28-56</u>   |                                  | REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>[Signature]</u>   |                                | ADDRESS<br><u>Sassah Funeral Home 7401 Belair Rd</u>                     |  |

BUREAU V. S.

OCT 1 1900

RECEIVED



10043

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |  |
| c. LENGTH OF STAY IN 1b<br><b>7 years</b>  |                                  | d. STREET ADDRESS<br><b>1001 West Joppa Road</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Mission Helpers Convent</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Sister Mary Boda (Hanly)</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>Oct. 5, 1956</b>  |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 30, 1874</b> |
| 9. AGE (In years last birthday) yrs.<br><b>81</b>  |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Nun</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Convent</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Brooklyn, New York</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Timothy Hanly</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ward</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  |
| 17. INFORMANT<br><b>Convent Records, 1001 West Joppa Rd. Towson</b>  |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b><br>DUE TO<br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>10 yrs.</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Oct 8, 1956</b> to <b>Oct 10, 1956</b> that I last saw the deceased alive on <b>Oct 6, 1956</b> and that death occurred at <b>11 P. M.</b> from the causes and on the date stated above.  |                                  |  |  |
| ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.  |                                  | ADDRESS (Street, city or town, state) <b>7501 York Road</b>  |  |
| PHYSICIAN'S NAME (Type) <b>Dr. Charles F. O'Donnell</b>  |                                  | DATE SIGNED <b>10/6/56</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Oct. 8, 1956</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Convent Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>1001 W. Joppa Rd. Towson, Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. Vernon Lemmon</b>  |                                  | ADDRESS<br><b>4611 Park Heights Ave.</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>8</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Mabel Griggs</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director.

1

1 1

1

1

1 1 1 1

1

1 1 1 1 1

1 1 1 1

1 1 1 1 1

1 1 1 1

1

1 1 1 1

1 1 1

1 1 1 1

1 1 1 1 1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

1001844  
Reg. Dist. No.

10044

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY                            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>   |   | c. LENGTH OF STAY IN 1b<br><b>6 Days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Veterans Administration Hospital</b>   |   | d. STREET ADDRESS<br><b>236 Hilton Street</b>   |   |
| 3. NAME OF DECEASED (Also: <b>ROBERT</b> <sup>First</sup><br>(Type or print)<br><b>ROBERT</b>  |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>30</b> Year <b>19 56</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>October 4, 1898</b>                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Printer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance Co.</b>   | 9. AGE (In years last birthday) yrs. <b>58</b>                              |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 13. FATHER'S NAME<br><b>Robert Hanna</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Susan Muir</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |   | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |   |
| 17. INFORMANT<br><b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>  |   | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>DIABETES MELLITUS</b><br><b>260X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>NEPHROSCLEROSIS</b> DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b><br><b>UNKNOWN</b> |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>VA</b>   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>October 24</b> , 19 <b>56</b> , to <b>October 30</b> , 19 <b>56</b> , and that death occurred at <b>3:45 P.</b> M. from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b><br>DATE SIGNED <b>10/31/56</b><br>ACTUAL SIGNATURE <b>Constantine J. Papastrat</b><br>PHYSICIAN'S NAME (Type) <b>CONSTANTINE J. PAPASTRAT, M.D. VAH, FORT HOWARD, MARYLAND</b>  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>11-2-56</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Edgar Lane</b><br>ADDRESS<br><b>Edgar Lane Funeral Home, Church Hill, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br><b>15 1956</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Hanson L. Harney</b>                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

NOV 2 1901

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10019

10045

CERTIFICATE OF DEATH

Reg. Dist. No.

33

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Keisterstown</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>13 years</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>MARY</u> Middle <u>BELLE</u> Last <u>HEIGES</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>30</u> Year <u>1956</u>  |  |  |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>May 12, 1881</u>  |  |
| 9. AGE (In years last birthday)<br><u>75</u> yrs.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Pennsylvania</u>                               |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |   |  | 13. FATHER'S NAME<br><u>Calvin Fensel</u>  |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Clara Belle Heller</u>   |  |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><u>No</u>   |  |  |  |
| 16. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT<br><u>Mr. Emory Heiges</u> Address <u>Keisterstown Md.</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma - liver</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c) |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 years</u>   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>August</u> , 19 <u>53</u> to <u>October 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>October 29</u> , 19 <u>56</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above. |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> M.D.   |  |   |  | ADDRESS (Street, city or town, state) <u>Keisterstown, Maryland</u>  |  |  |  |
| DATE SIGNED <u>Oct 30, 1956</u>   |  |   |  |  |  |  |  |
| PHYSICIAN'S NAME (Type)   |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>Nov. 3, 1956</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>B-92574-1770</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>B-92574-1770, Pa.</u>                      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>J. F. Cline &amp; Sons</u>   |  |   |  | ADDRESS<br><u>Keisterstown Md.</u>   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>10-30-56</u>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>Mary B. Cline</u>  |  |   |  |  |  |  |  |

BUREAU V. S.

NOV 1 1936

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10020 33  
Reg. Dist. No.

10046

|   |  |   |  |  |  |  |   |
|---|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>         |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Owings Mills</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>2 years 7 mo.</u>  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Rosewood State Tng School</u>  |  |   |  | d. STREET ADDRESS<br><u>3101 DuBois Ave</u>  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Rodney Earl</u> Middle <u>Hellmig</u> Last <u>Hellmig</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>29</u> Year <u>1956</u>  |  |  |   |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>12/5/52</u>                                     |   |
| 9. AGE (In years last birthday)<br><u>3</u> yrs.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Minor</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Md.</u>                |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 13. FATHER'S NAME<br><u>Earl Francis Hellmig</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Marielyn Elizabeth Miller</u>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO<br><u>None</u>   |  | 17. INFORMANT<br><u>Meredith S. Hale</u> Address <u>Rosewood State Tng School</u>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>as Central respiratory failure</u><br><u>4700 355x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Organic brain lesions</u><br>DUE TO (c) <u>Kernicterus</u> |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
| 20f. (City or town)   |  |   |  | 20g. (County)  |  | 20h. (State)   |   |
| 21. I certify that I attended the deceased from <u>3/15/</u> 19 <u>54</u> , to <u>10/29</u> 19 <u>56</u> , that I last saw the deceased alive on <u>10/29</u> 19 <u>56</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED <u>10/30/56</u>                           |  |   |  |  |  |  |   |
| ACTUAL SIGNATURE <u>Rich. Lindenberg</u> (Pathologist)  |  |   |  | PHYSICIAN'S NAME (Type) <u>Richard Lindenberg, Pathologist</u>   |  |  |   |
| 22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)   |  | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)                          |   |
| <u>BURIAL</u>   |  | <u>10-31-56</u>   |  | <u>PARKWOOD</u>  |  | <u>BALTO, Md.</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Charles H. ...</u>   |  |   |  | ADDRESS<br><u>8802 Harford Rd.</u>   |  | 24. REG'D BY REGISTRAR<br><u>SV 2 1556</u>                             |   |
| 25. REGISTRAR'S SIGNATURE<br><u>Mary Elsie</u>  |  |   |  |  |  |  |   |

BUREAU V. 1

NOV 2 1956

RECEIVED



may be relayed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9981

CERTIFICATE OF DEATH

10021

Reg. Dist. No.

|   |                                  |   |   |   |   |   |  |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Ealethorne</u>   |                                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Ealethorne</u>                                   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>4005 Lincoln Drive</u>   |                                  |   |   | d. STREET ADDRESS<br><u>4005 Lincoln Drive</u>  |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>George Daniel Henry</u>   |                                  |   |   | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>22</u> Year <u>1969</u>   |   |   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Oct. 3, 1900</u> | 9. AGE (In years last birthday) yrs<br><u>69</u>  | IF UNDER 1 YEAR: IF UNDER 24 HRS<br>Months Days Hours Min |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Capt. Supt.</u>   |                                  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Fidelity Deposit Co. Baltimore, Md.</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>U.S.</u>                    |  |
| 13. FATHER'S NAME<br><u>George W. Henry</u>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Margaret Elizabeth Gows</u>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no or unknown) <u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>213-10-4222</u>   |   | 17. INFORMANT<br>Address<br><u>Donald D. Barrett 1200 Penobscot Rd.</u>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis -</u><br>DUE TO <u>Sudden cardiac infarction - E. arrhythmia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Postoperative</u><br>DUE TO (c) <u>Postoperative</u> |                                  |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Unrecorded</u><br><br><u>10 days previous</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>10</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>Oct 22</u> , 19 <u>70</u> , to <u>Oct 22</u> , 19 <u>70</u> , that I last saw the deceased alive on <u>Oct 22</u> , 19 <u>70</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.   |                                  |   |   |   |   |   |  |
| ACTUAL SIGNATURE <u>Frederic V. Beiler</u>  |                                  |   |   | ADDRESS (Street, city or town, state) DATE SIGNED <u>1014 Francis Ave - Balt. 27-Md</u>   |   |   |  |
| PHYSICIAN'S NAME (Type) <u>FREDERIC V. BEILER</u>   |                                  |   |   |   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>10/22/70</u>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Don Park Cemetery</u>  |   | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Howard J. Hubbard</u>  |                                  |   |   | ADDRESS<br><u>410 Wilkens Avenue</u>  |   | 24a. REC'D BY REGISTRAR<br>DATE <u>10/22/70</u>                             |  |
|   |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><u>Geo M. Kieffers</u>  |   |   |  |

LIBRARY

OCT 5 1956

RECEIVED

10047

## CERTIFICATE OF DEATH

10022

Reg. Dist. No.

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL-ROCKDALE</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - ROCKDALE</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>8343 LIBERTY Rd</b>  |   | d. STREET ADDRESS<br><b>8343 LIBERTY Rd</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ALICE</b> Middle <b>ESTELLE</b> Last <b>HERSHBERGER</b>   |   | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>2</b> Year <b>1956</b>  |   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MARCH 29, 1875</b>   |
| 9. AGE (In years last birthday) <b>81</b> yrs   |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOUSEWIFE</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>SAUNDERS</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>NOT KNOWN</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |   | 16. SOCIAL SECURITY NO. <b>NONE</b>  |   |
| 17. INFORMANT<br><b>SON - WAYNE HERSHBERGER</b>   |   | Address <b>8343 LIBERTY Rd BALTO. 7, Md.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>UREMIA</b><br>DUE TO <b>HYPERTENSION -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b><br>(c)   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 WEEKS</b><br><b>15 YEARS.</b>              |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>JANUARY</b> , 19 <b>50</b> to <b>OCTOBER 2</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>OCTOBER 1</b> , 19 <b>56</b> , and that death occurred at <b>4:33A</b> M. from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>8204 LIBERTY Rd BALTO 7, Md.</b> DATE SIGNED <b>10/4/56</b> |   |  |   |
| ACTUAL SIGNATURE <b>Edwin L. Pierpont</b> M.D.  |   | PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT MD 8204 LIBERTY Rd - BALTO. 7, Md.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>10/5/56</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b>                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Vickers &amp; Sons - Balto. 17, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br><b>DATE</b>   | 24b. REGISTRAR'S SIGNATURE  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO GENERAL FACTOR: After this certificate has been signed by the attending physician and completed by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13 'A 0711

9-81

11.01 A 07

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. This certificate is to be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ML(5)  
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |  |   |  |   |  |  |   |   |   | 10023 44                         |
|--|--|---|--|---|--|--|---|---|---|----------------------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |   |   | Reg. Dist. No.                   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE Co.</b> MARYLAND   |  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY                               |  |   |   |   |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SPARROWS POINT</b>  |  |   |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b>   |  |   |   |   |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>BETHLEHEM STEEL CO., INC.</b>   |  |   |  |   | d. STREET ADDRESS<br><b>739 S. GRUNDY ST.</b>  |  |   |   |   |                                  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |   |   |   |                                  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>GEORGE RICHARD HEYMAN</b>   |  |   |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>10 27 19 56</b>   |  |   |   |   |                                  |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>                            |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>JAN. 19, 1898</b> |   | 9. AGE (In years last birthday)<br><b>58</b> yrs. |   |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BRICK LAYER</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>BETH. STEEL CO.</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MD.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?             |   |   |   |                                  |
| 13. FATHER'S NAME<br><b>GEORGE R. HEYMAN.</b>  |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br><b>MARY A. LEHR.</b>   |  |   |   |   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b> <b>WORLD WAR I</b>  |  |   |  |   | 16. SOCIAL SECURITY NO.  |  |   |   |   |                                  |
| 17. INFORMANT<br><b>MAGDALEN HEYMAN</b>  |  |   |  |   | Address<br><b>SAME.</b>  |  |   |   |   |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fracture Dislocation Lumbar Spine</b><br>DUE TO <b>912.3</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Fracture Left Tibia &amp; Fibula</b><br>DUE TO<br>(c)   |  |   |  |   |  |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |   |   |   |                                  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Hit by fork lift arm while in box car at work</b> |  |   |   |   |                                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>3:20</b> p. m. <b>10/27/59</b>  |  |   | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Shipping rd</b>   |  | 20f. (City or town) (County) (State)<br><b>Bethlehem Steel Co. Balto. Md.</b> |   |   |                                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |   |  |   |  |  |   |   |   |                                  |
| ACTUAL SIGNATURE <b>William V. [Signature]</b> M.D.  |  |   |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   |   |                                  |
| EXAMINER'S NAME (Type)   |  |   |  |   | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |   |   |                                  |
|  |  |   |  |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   |   |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL 10-31-56</b>  |  |   |  |   | 22b. DATE THEREOF  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART CEM</b>                 |   | 22d. LOCATION (City, town, or county) (State)<br><b>7401 TERMAN HILL RD., MD.</b> |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles S. Guiler</b>   |  |   |  |   | ADDRESS<br><b>901 S. CONKLING ST. BALTO., MD.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>10-30-56</b>                                    |   | 24b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                  |                                  |

BUREAU V. 3

OCT 31 1956

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12

10024

10049

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY                                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |  | c. LENGTH OF STAY IN 1b<br><b>12 days</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SPRING GROVE STATE HOSPITAL</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | d. STREET ADDRESS<br><b>3829 Park Heights Avenue</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Regina</b> Middle <b>Hirshman</b> Last   |  | 4. DATE OF DEATH<br>Month <b>October 25,</b> Day <b>19</b> Year <b>56</b>   |   |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b>       | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1902</b>                                   |
| 9. AGE (In years last birthday)<br><b>54</b> yrs   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Poland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Isaac Lewkowicz</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Fajgla Brown</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO<br><b>unknown</b>  |   |
| 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) |  |   |   |
| INTERVAL BETWEEN ONSET AND DEATH   |  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>October 14, 1956</b> , to <b>October 25, 1956</b> , that I last saw the deceased alive on <b>Oct. 25</b> , 19 <b>56</b> , and that death occurred at <b>11:55aM</b> , from the causes and on the date stated above.   |  |   |   |
| ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.   |  | ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>10-25-56</b>  |   |
| PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>  |  | <b>Catonsville 28, Maryland</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>10-26-1956</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>ROSEDALE</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>BALTO. MD</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Jack Lewis Inc - 2100 Eutan Place</b>   |  | 24a. REC'D BY REGISTRAR<br><b>DATE 29 1956</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>G. Harry</b>  |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO NEERL FACTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 1

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10050

CERTIFICATE OF DEATH

10025

Reg. Dist. No. 45

|   |                                  |   |  |   |  |  |  |
|---|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>514 ESSEX</b>  |                                  |   |  | c. LENGTH OF STAY IN lb<br><b>LIFE</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>204 MACE AVENUE</b>  |                                  |   |  | e. STREET ADDRESS<br><b>204 Mace AVENUE</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>WILLIAM HORMANN</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>8</b> Year <b>1956</b>  |  |  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>FEB. 17, 1883</b> | 9. AGE (In years last birthday)<br><b>73</b> yrs.   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                                  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE MARYLAND.</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>KARL HORMANN</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH ?</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, No, (unknown))<br><b>NO</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>215 03 3781</b>   |  | 17. INFORMANT<br><b>MRS ELIZABETH HORMANN</b>   |  | Address<br><b>SAME.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary arterio sclerosis</b><br>DUE TO<br>(c)  |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs.</b><br><b>? yrs.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19  |                                  |   |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>                   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |
| 21. I certify that I attended the deceased from <b>march, 1956</b> , to <b>10/8</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10/1</b> , 19 <b>56</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>434 Eastern Ave</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>J. PLATT, M.D.</b> M.D. <b>Cosy. m.d.</b><br>PHYSICIAN'S NAME (Type) |                                  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, or other disposal (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>OCT. 11, 56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN CEMETERY</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>BALTIMORE MARYLAND.</b>                                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>HENRY SANDER &amp; SONS INC BALTIMORE MD.</b>  |                                  |   |  | 24a. REC'D BY REGISTRAR<br><b>DATE 11 10 56</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Edith Hurling</b>   |  |

BUREAU V. S.

201 11 1956



1

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10026

## CERTIFICATE OF DEATH

Reg. Dist. No. 39

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>COUNTY <u>Baltimore</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>Winkton</u><br>TOWN <u>Winkton</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Irish Ave.</u>                  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Md</u> COUNTY <u>Balte</u><br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>Winkton</u><br>OR TOWN <u>Winkton</u><br>STREET ADDRESS (If rural give location) <u>Irish Ave.</u> |  |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)<br><u>Rosalba Cecilia Houck</u>  |                                  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Oct 14 1956</u>   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>Widowed</u>  | 8. DATE OF BIRTH<br><u>July 5 1873</u> |
| 9. AGE last birthday<br><u>83</u> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.         |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>   |                                  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                                  | 13. FATHER'S NAME<br><u>Lester Meredith Birmingham</u>  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Alveta Hawkins</u>  |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)<br><u>no</u>  |  |
| 16. SOCIAL SECURITY NO.<br><u>---</u>  |                                  | 17. INFORMANT & ADDRESS<br><u>son Howard Houck, Winkton, Md.</u>  |  |
| 18. MEDICAL CERTIFICATION  |                                  |   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                  |   | INTERVAL BETWEEN ONSET AND DEATH       |
| IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>   |                                  |   | <u>5 days</u>                          |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardio-vascular disease</u>   |                                  |   | <u>6 years</u>                         |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>disease</u>  |                                  |   |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                  |   |  |
| 19a. DATE OF OPERATION   |                                  | 19b. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)  |  |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |                                  | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 21f. HOW DID INJURY OCCUR?   |                                  |   |  |
| 22. I hereby certify that I attended the deceased from <u>Nov. 1950</u> , to <u>Oct 14 1956</u> , that I last saw the deceased alive on <u>Oct 10 1956</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above. |                                  |   |  |
| SIGNATURE<br><u>Elizabeth B. Shumell</u>   |                                  | DATE SIGNED<br><u>Oct 14 1956</u>   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |                                  | 24. REC'D BY REGISTRAR<br>DATE <u>10/16/56</u>  |  |
| DATE THEREOF<br><u>10-17-56</u>  |                                  | NAME OF CEMETERY OR CREMATORY<br><u>West Liberty</u>  |  |
| REGISTRAR'S SIGNATURE<br><u>M. Elizabeth Kowach</u>  |                                  | LOCATION (City, town, or county) (State)<br><u>White Hall, Md.</u>  |  |
| 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>F. Scott Brooks, Sparks, Md.</u>  |                                  | ADDRESS<br><u>---</u>   |  |

B. A. C.

10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, who should be detached for use as the burial-transit permit. Then please remove carbon papers, ages 1 or 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9973 CERTIFICATE OF DEATH

10027

Reg. Dist. No.

41

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>6825 Holabird Ave.</b>   |   | d. STREET ADDRESS<br><b>6825 Hoslabird Ave.</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LIZZIE</b> Middle <b>P.</b> Last <b>HUGHES</b>  |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>23</b> Year <b>19 56</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 15, 1868</b>                             |
| 9. AGE (In years last birthday)<br><b>87 yrs.</b>   |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At home</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>William Porter</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Rebecca Collins</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No.</b>   |   | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Howard P. Hughes</b>  |   | Address<br><b>2 Winona Ave-22</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Mc SENTERIC Thrombosis</b><br><b>445X</b> DUE TO <b>Hypertension &amp; A-S-Cardio Vascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Arricular Fibrillation</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>30 hrs</b><br><b>15 yrs</b><br><b>1 mo -</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Chronic R. vent Choleliths</b>  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Oct 22, 1956</b> to <b>Oct 23, 1956</b> , that I last saw the deceased alive on <b>Oct 23, 1956</b> , and that death occurred at <b>6:45 P. M.</b> from the causes and on the date stated above.   |   |  |  |
| ACTUAL SIGNATURE<br><b>M. B. Davis</b>  |   | M.D. <b>6800 Morningstar Rd</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>M. B. DAVIS M.D.</b>  |   | ADDRESS (Street, city or town, state)<br><b>Dundalk, Md.</b>   |  |
| DATE SIGNED<br><b>10/23/56</b>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>Oct. 26, 1956</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Colgate, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ullrich Funeral Home</b>   |   | ADDRESS<br><b>2112 Dundalk Ave.</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>Oct 24 1956</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Thm. Higgins</b>  |  |

BUREAU V. 3

OCT 23 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10028

Reg. Dist. No.

47

9982

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Balto</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Balto</u>                                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>  |  | c. LENGTH OF STAY IN 1b  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3630 Washington Blvd</u>  |  | d. STREET ADDRESS <u>3630 Wash Blvd</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Adelle Humbley</u>   |  | 4. DATE OF DEATH <u>Oct 19</u> 19 <u>56</u>  |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>Col</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>             | 8. DATE OF BIRTH <u>June 3 1899</u>                            |
| 9. AGE (in years last birthday) <u>64</u> yrs.  |  | 10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>4</u> Hours <u>19</u> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Ala</u>  |  | 12. CITIZEN OF WHAT COUNTRY <u>USA</u>   |  |
| 13. FATHER'S NAME <u>Lobias Stewart</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Louise Cook</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <u>Belke Humbley Wash Blvd</u>  |  | Address <u>3630</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u><br><u>443X</u> DUE TO (b) <u>Hypertension Cordis Vasculi</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>disease</u>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                           |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |  |  |
| ACTUAL SIGNATURE <u>GEO S M KIEFFER</u>   |  | DATE SIGNED <u>OCT 22 56</u>   |  |
| EXAMINER'S NAME (Type) <u>GEO S M KIEFFER</u>   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>OCT 22 56</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>St Lukes Cem</u>   | 22d. LOCATION (City, town, or county) (State) <u>Harmon Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs Kate R Williams</u>   |  | 24a. REC'D BY REGISTRAR <u>Schmidt</u> 24b. REGISTRAR'S SIGNATURE <u>Dr. Geo M. Kieffer</u>  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the coroner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. For burial, cremation, or removal, file pages 1 and 2 with the registrar.

RECEIVED

17 10 1956

BUREAU V. E.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

10029

10052

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY <b>Baltimore</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Mission Helpers Convent, 1001 W. Joppa Rd.</b>   |                                  | d. STREET ADDRESS<br><b>1001 West Joppa Road</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Sister Mary Providencia (Hurley)</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>DECEASED 10/9/56 19</b>   |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 22, 1877</b> |
| 9. AGE (In years last birthday)<br><b>79</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Nun</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Convent</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>County Cork, Ireland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>John Hurley</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Catherine O'Leary</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |   |
| 17. INFORMANT<br><b>Convent Records, 1001 W. Joppa Road, Towson</b>   |                                  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiac</b><br>DUE TO (c) <b>Vascular Disease</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b><br><b>10 1/2</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>Nov 1949</b> to <b>October 9, 1956</b> , that I last saw the deceased alive on <b>October 8, 1956</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.  |                                  |  |   |
| ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.   |                                  | ADDRESS (Street, city or town, state) <b>7501 York Road</b>  |   |
| PHYSICIAN'S NAME (Type) <b>Dr. Charles F. O'Donnell</b>   |                                  | DATE SIGNED <b>Oct. 10, 1956</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>Oct. 12, 1956</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Convent Cemetery,</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>1001 W. Joppa Rd. Towson, Md.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. Vernon Lemmon</b>   |                                  | ADDRESS<br><b>4611 Park Heights Ave.</b>   |   |
| 24a. REC'D BY REGISTRAR<br><b>DATE 11-1-56</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Thaddeus</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 'A' DEPT

1961

10053

## CERTIFICATE OF DEATH

Reg. Dist. No.

30

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Baltimore</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland.</b> b. COUNTY <b>Baltimore</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>929 Saint Agnes Lane</b>  |   | d. STREET ADDRESS<br><b>929 Saint Agnes Lane</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Virginia</b> Middle <b>M.</b> Last <b>Immler</b>  |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>26</b> Year <b>1956</b>  |  |
| 5. SEX<br><b>F.</b>   | 6. COLOR OR RACE<br><b>W.</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 11, 1918</b>  |
| 9. AGE (In years last birthday)<br><b>38</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>H.W.</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>O.H.</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Louis Little</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Josephine Iacovetti</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>George A. Immler, 929 St. Agnes Lane, Catonsv.</b>  |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma Left Breast with Generalized Metastases</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) DUE TO<br>(c)  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b>                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>6/10/55</b> , 19____, to <b>10/26/56</b> , 19____, that I last saw the deceased alive on <b>10/26/56</b> , 19____, and that death occurred on <b>8.10 PM</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Joseph G. Laukaitis M.D.</b><br>ACTUAL SIGNATURE<br>PHYSICIAN'S NAME (Type) <b>JOSEPH G. LAUKAITIS, M.D.</b> <b>679 WASHINGTON BLVD. BALTO 30-MD</b> |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>Oct. 30/56</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Harry H. Witzke</b>  |   | ADDRESS<br><b>4101 Edmondson</b>  | 24a. REC'D. BY REGISTRAR<br><b>Oct. 30, 1956</b>                                       |
|   |   | 24b. REGISTRAR'S SIGNATURE<br><b>V. E. Harry</b>  |  |

MEDICAL CERTIFICATION

THIS CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in duplicate, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 31 1956

BUREAU V. S.

10051

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |   | c. LENGTH OF STAY IN 1b<br><b>28yr7mt19dys</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>  |   | d. STREET ADDRESS<br><b>Ridge Rd. - Rt. #1 - Reisterstown</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>George PAVLEAD Jackson</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>October 7 19 56</b>  |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 21, 1892</b>  |
| 9. AGE (In years last birthday)<br><b>64 yrs</b>   |   | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>farmer</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>farming</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>James W. Jackson</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Jane Algire</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |   | 16. SOCIAL SECURITY NO<br><b>unknown</b>  |  |
| 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure due to</b><br><b>443X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>pulmonary - hypertensive</b><br>DUE TO (c) <b>cardiovascular disease</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br>19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>Oct. 2, 19 56</b> , to <b>10-7-56</b> , that I last saw the deceased alive on <b>10-7-56</b> , and that death occurred at <b>4:00 A.M.</b> , from the causes and on the date stated above   |   |   |  |
| ACTUAL SIGNATURE<br><b>Stella Wachler</b>  |   | ADDRESS (Street, city or town, state)<br><b>SPRING GROVE STATE HOSPITAL</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>Stella Wachler, M. D.</b>  |   | DATE SIGNED<br><b>Catonsville 28, Maryland</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 22b. DATE THEREOF<br><b>OCT. 9, 19 56</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>ARCADIA LUTHERAN CEM.</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>ARCADIA, BALTO. CO., MD.</b>       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John Bunn's Sons</b>  |   | 24a. REC'D BY REGISTRAR<br><b>DATE</b>  |  |
| ADDRESS<br><b>Towson, Md.</b>  |   | 24b. REGISTRAR'S SIGNATURE  |  |

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO GENERAL REGISTRAR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 10 1944

BUREAU A. F.

10055

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                               |  |                                       |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>             |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>  |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7531 Durwood Rd</u>   |                               | d. STREET ADDRESS <u>7531 Durwood Rd</u>   |                                       |
| 3. NAME OF DECEASED (Type or print) <u>Minnie Delmar Joiner</u>   |                               | 4. DATE OF DEATH <u>Oct. 13, 1956</u>  |                                       |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 14, 1886</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs.  |                               | 10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>   |                                       |
| 11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md</u>  |                               | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>  |                                       |
| 13. FATHER'S NAME <u>Benjamin Sewell</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Unknown Unknown</u>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>215-05-9139B</u>  |                                       |
| 17. INFORMANT <u>Mr. John Joiner</u>  |                               | Address <u>7531 Durwood Rd</u>   |                                       |
| 18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension C-V. Disease</u><br>(c) <u>  </u>   |                               | INTERVAL BETWEEN ONSET AND DEATH <u>  </u>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>   |                               |  |                                       |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>  |                                       |
| 20c. TIME OF INJURY Month, Day, Year <u>  </u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>  |                               | 20f. (City or town) (County) (State) <u>  </u>   |                                       |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                               |  |                                       |
| ACTUAL SIGNATURE <u>M B Davis</u>   |                               | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                       |
| EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>  |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>Oct. 16, 1956</u>   |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>  |                               | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>  |                               | 24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>  </u>   |                                       |
| ADDRESS <u>7401 Belair Rd</u>   |                               | DATE <u>Oct 17 1956</u> <u>Wm. M. Kelly, Jr.</u>   |                                       |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your file. The Registrar provides burial, cremation, or removal.

RECEIVED  
U. S.

RECEIVED  
U. S.



## CERTIFICATE OF DEATH

Reg. Dist. No.

9983

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Id.</u> b. COUNTY <u>Baltimore</u>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Arbutus</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Arbutus</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>1533 Knecht Ave</u>   |                                  | d. STREET ADDRESS<br><u>1533 Knecht Ave</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Elizabeth A. Kahmer</u>  |                                  | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>4</u> Year <u>1956</u>  |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 31, 1878</u> |
| 9. AGE (In years last birthday)<br><u>76</u> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>home</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Md.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>  </u>  |   |
| 13. FATHER'S NAME<br><u>Conrad Plock</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Bertha</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>none</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>no ne</u>  |   |
| 17. INFORMANT<br><u>Louis V. Kahmer, 1533 Knecht Ave</u>   |                                  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u><br>(c) <u>Arteriosclerotic C.V.D.</u> |                                  |  |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>instantaneous</u>   |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>  |                                  |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>1-1-46</u> , 19 <u>  </u> , to <u>10-4-56</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>9-25-56</u> , 19 <u>  </u> , and that death occurred at <u>4:05 P.</u> M, from the causes and on the date stated above.   |                                  |  |   |
| ACTUAL SIGNATURE <u>Nathan Racusin</u>   |                                  | ADDRESS (Street, city or town, state) DATE SIGNED<br><u>206 S-Gilmer st. Balto 23 Md</u><br><u>10-5-56</u>                                       |   |
| PHYSICIAN'S NAME (Type) <u>NATHAN RACUSIN</u>  |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>10-8-56</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Carmel</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Howard Hubbard, 4107 Wilkens Ave</u>  |                                  | 24a. REC'D BY REGISTRAR<br><u>0078</u> DATE <u>8 1956</u>  |   |
| 24b. REGISTRAR'S SIGNATURE   |                                  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO GENERAL FACTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JOHN A. H.

1956

1000 8-11-56

## CERTIFICATE OF DEATH

10034

Reg. Dist. No. 30

10056

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Ellicott City</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Ellicott City</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Westchester Avenue</b>  |   | d. STREET ADDRESS<br><b>Westchester Avenue</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>MICHAEL</b> Last <b>KAISER</b>   |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>2nd.</b> Year <b>19 56</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Mar. 3, 1874</b>                                    |
| 9. AGE (In years last birthday)<br><b>82</b> yrs   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Foreman Baltimore Co.</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Roads Dept.</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>Michael Kaiser</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Yath</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>Mrs. Anna Kaiser</b>   |   | Address <b>Westchester Ave. Ellicott City Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</b><br>DUE TO <b>DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>PULMONARY EDEMA</b><br>DUE TO<br>(c) <b>PNEUMONITIS</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that I attended the deceased from <b>9/21</b> , 19 <b>55</b> , to <b>10/2</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11/2</b> , 19 <b>56</b> , and that death occurred at <b>12:10 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>5800 EDMONDSON AVE. MD.</b> DATE SIGNED <b>10/2/56</b>  |   |   |  |
| ACTUAL <b>John H. Shaw</b> M.D.  |   |   |  |
| PHYSICIAN'S NAME (Type) <b>JOHN H. SHAW M.D.</b>   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>10/5/56</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Good Shepherd</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Ellicott City, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Easton Sons</b>   |   | ADDRESS<br><b>Catonsville, Md.</b>  | 24a. REC'D BY REGISTRAR<br><b>DATE 10-4-56</b>                             |
|  |   | 24b. REGISTRAR'S SIGNATURE<br><b>T. E. Harvey</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3, may be detached for use as the burial-transit permit. Then please remove carbon paper and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 X 170800

156

100000

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10035

Reg. Dist. No.

10057

|   |                               |  |                                       |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>                  |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodstock</b>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodstock</b>  |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Woodstock College</b>   |                               | d. STREET ADDRESS <b>Woodstock College</b>   |                                       |
| 3. NAME OF DECEASED (Type or print) <b>Jerome T. Kane Sr.</b>   |                               | 4. DATE OF DEATH <b>October 31 19 56</b>   |                                       |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <b>Oct. 31, 1893</b> |
| 9. AGE (In years last birthday) <b>63</b> yrs.  |                               | 10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Receptionist at Woodstock College</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>  |                                       |
| 11. BIRTHPLACE (State or foreign country) <b>U.S.</b>   |                               | 12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>  |                                       |
| 13. FATHER'S NAME <b>Bartholme, Kane</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Mary Nallen</b>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>no</b> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <b>220-03-8347</b>   |                                       |
| 17. INFORMANT <b>Jerome T. Kane Jr.</b>   |                               | 18. ADDRESS <b>1506 North Rolling Road, Baltimore</b>  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Hemorrhage</b><br><b>1783.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>none</b><br>(c), stating the underlying cause last. <b>none</b> DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> |                               |  |                                       |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                       |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>   |                                       |
| 20c. TIME OF INJURY Month, Day, Year <b>none 19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>  |                               | 20f. (City or town) (County) (State) <b>none</b>   |                                       |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .                           |                               |  |                                       |
| ACTUAL SIGNATURE <b>D.D. Caples</b>   |                               | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                       |
| EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>   |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                       |
|   |                               | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>Nov. 3, 1956</b>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>   |                               | 22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Howard Strong, Baltimore, Md.</b>  |                               | 24a. REC'D BY REGISTRAR <b>Nov 5 1956</b>  |                                       |
|   |                               | 24b. REGISTRAR'S SIGNATURE <b>Dr. Tom E. Martin</b>  |                                       |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be mailed for your file. This certificate is valid for burial, cremation, or removal.

BUREAU V. A.

1933

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10058

## CERTIFICATE OF DEATH

10036 30

Reg. Dist. No.

|   |  |                             |  |   |  |  |  |
|---|--|-----------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTO.</u> MARYLAND   |  |                             |  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>b. STATE <u>MD.</u> c. COUNTY <u>Mt. Balto</u>                              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>   |  |                             |  | c. LENGTH OF STAY IN 1b <u>42 yrs. 3 Mo</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove Hospital</u>   |  |                             |  | d. STREET ADDRESS   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>A.</u> Middle <u>KEIDEL</u> Last   |  |                             |  | 4. DATE OF DEATH <u>10-7-</u> 19 <u>56</u> Month Day Year   |  |  |  |
| 5. SEX <u>F</u>   |  | 6. COLOR OR RACE <u>W</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>9/10/1878</u>                                      |  |
| 9. AGE (In years last birthday) <u>78</u> yrs.  |  | IF UNDER 1 YEAR Months Days |  | IF UNDER 24 HRS. Hours Min.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>  |  |                             |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>  |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u>  |  |                             |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |  |  |
| 13. FATHER'S NAME <u>George Frazier</u>   |  |                             |  | 14. MOTHER'S MAIDEN NAME <u>Mary Laurer</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)   |  |                             |  | 16. SOCIAL SECURITY NO. <u>None</u>   |  |  |  |
| 17. INFORMANT <u>Mrs. Agnes Frazier</u> Address <u>Finks burg Md.</u>   |  |                             |  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>carcinoma pancreas with</u><br><u>liver metastasis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>liver metastasis</u><br>DUE TO (c) <u>liver metastasis</u>  |  |                             |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>   |  |                             |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                             |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  |                             |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)  |  |                             |  |   |  |  |  |
| 21. I certify that I attended the deceased from <u>7-1-</u> 19 <u>54</u> to <u>10-7-</u> 19 <u>56</u> that I last saw the deceased alive on <u>10-7-</u> 19 <u>56</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE <u>Daniel Edwards MD</u> M.D. <u>DAVID E. EDWARDS</u> <u>10-7-56</u><br>PHYSICIAN'S NAME (Type) <u>DAVID E. EDWARDS</u> <u>Spring Grove Hospital, Catonsville</u> |  |                             |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  |                             |  | 22b. DATE THEREOF <u>10/21/56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>                    |  |
| 22d. LOCATION (City, town, or county) (State) <u>Md.</u>  |  |                             |  |   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. T. ...</u> ADDRESS <u>...</u>  |  |                             |  | 24a. REC'D BY REGISTRAR <u>...</u> DATE <u>...</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>...</u>                                  |  |

MEDICAL CERTIFICATION

THIS CERTIFICATE IS ATTENDED BY PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, pages 1 and 2, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 9 1956

BUREAU A. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10037

10059

Reg. Dist. No.

|  |  |  |   |   |   |  |  |
|--|--|--|---|---|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>BALTO</u> MARYLAND  |  |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SPARROWS POINT 19</u>   |  | c. LENGTH OF STAY IN 1b<br><u>LIFE</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SPARROWS POINT 19</u>                                    |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>628 E ST.</u>   |  |  |   | d. STREET ADDRESS<br><u>628 E ST.</u>   |   |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>MARGARET DAILEY KELLY</u>   |  |  |   | <b>4. DATE OF DEATH</b><br>Month <u>OCT.</u> Day <u>27</u> Year <u>1952</u>   |   |  |  |
| <b>5. SEX</b><br><u>FEMALE</u>   | <b>6. COLOR OR RACE</b><br><u>WHITE</u>  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>DEC. 8, 1914</u>  | <b>9. AGE</b> (In years last birthday)<br><u>41</u> yrs.  | <b>IF UNDER 1 YEAR</b><br>Months <u>—</u> Days <u>—</u>     |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>—</u>   |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>MD.</u>  |   |  |  |
| <b>13. FATHER'S NAME</b><br><u>HENRY DAILEY</u>  |  |  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>NORMA BOTTOMSTONE</u>   |   |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, unknown)<br><u>NO</u>   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>213-07-6188</u>   |   | <b>17. INFORMANT</b><br>Address <u>EDW. J. KELLY — SAME</u>   |   |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>4:00.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>—</u><br>(c), stating the underlying cause lost. DUE TO <u>—</u>  |  |  |   |   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>   |  |  |   |   |   |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/><br>CAUSE OF DEATH.   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)   |   |   |   |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>   | <b>20d. INJURY OCCURRED</b><br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |   | <b>20f. (City or town)</b> (County) (State)   |   |  |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> . |  |  |   |   |   |  |  |
| <b>ACTUAL SIGNATURE</b><br><u>Jack C Collins</u>   |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>   |   | <b>DATE SIGNED</b><br><u>10-29-52</u>   |   |  |  |
| <b>EXAMINER'S NAME (Type)</b><br><u>Jack C Collins</u>   |  | <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>   |   | <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>  |   |  |  |
| <b>22a. BURIAL, CREMATION, or REMOVAL (Specify)</b><br><u>BURIAL</u>   |  | <b>22b. DATE THEREOF</b><br><u>10-30-56</u>  |   | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>OAK LAWN</u>  |   |  |  |
| <b>22d. LOCATION (City, town, or county)</b><br><u>BALTO. CO., MD</u>  |  | <b>22e. (State)</b>  |   |   |   |  |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Walter Arthur Bradley, Reudauch, Md</u>  |  |  | <b>24a. REC'D BY REGISTRAR</b><br>DATE <u>—</u> |   | <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Harold L. Carls</u> |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PWS-3. Pages 1, 2, and 3 may be retained by your files. The funeral director may be registered with the State Department of Health, Baltimore, Maryland, or removal.

RECEIVED

NOV 19 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10038

10060

CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |                                       |   |  |  |   |
|--|----------------------------------|--|---------------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                                  |  |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |                                  |  |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>2553 Windsor Road</u>   |                                  |  |                                       | d. STREET ADDRESS<br><u>2553 Windsor Road</u>   |  |  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>John Joseph</u>  |                                  |  |                                       | 4. DATE OF DEATH Month Day Year<br><u>10 16 1956</u>  |  |  |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov 7 1878</u> | 9. AGE (In years last birthday) yrs.<br><u>77</u>   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  |  |                                       | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><u>Thomas E. Grace</u>  |                                  |  |                                       | 14. MOTHER'S MAIDEN NAME<br><u>Jusan R. Preston</u>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                                  |  |                                       | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address<br><u>Raymond E. Grace</u>                       |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. Disease</u><br><u>Heart</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO<br>(c) _____   |                                  |  |                                       |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |                                       |   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                                  |  |                                       | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
|  |                                  |  |                                       | 20f. (City or town) (County) (State)  |  |  |   |
| 21. I certify that I attended the deceased from <u>10/14</u> , 19 <u>54</u> to <u>10/16/56</u> , that I last saw the deceased alive on <u>10/13</u> , 19 <u>56</u> , and that death occurred at <u>5:00 P.</u> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><u>Ruthen Janney</u> M.D. <u>7101 Harford Rd. Balto., Md.</u> |                                  |  |                                       |   |  |  |   |
| ACTUAL SIGNATURE   |                                  |  |                                       |   |  |  |   |
| PHYSICIAN'S NAME (Type) <u>7101 Harford Rd. Balto., Md.</u>  |                                  |  |                                       |   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 22b. DATE THEREOF  |                                       | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or county) (State)                          |   |
| <u>Burial</u>  |                                  | <u>10/16/56</u>  |                                       | <u>St. Elizabeth's</u>  |  | <u>St. Michaels</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>A. Gableton</u> <u>1.10 1.10</u>  |                                  |  |                                       | 24a. REC'D BY REGISTRAR DATE  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Dr. Wm. E. Masterson</u>              |   |

100 OCT 22 1956

BUREAU V. S.

OCT 22 1966

RECEIVED

## Reg. Dist. No.

|  |  |  |  |   |  |   |  |  |  |  |  |   |  |                  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|---|--|------------------|--|
| 1. PLACE OF DEATH<br>o. COUNTY   |  | BALTIMORE  |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>o. STATE |  | MARYLAND   |  | b. COUNTY                                    |  | ANNE ARUNDEL  |  |                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  | FORT HOWARD  |  | c. LENGTH OF STAY IN lb   |  | 86 DAYS   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |  | ODENTON                                      |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  | VETERANS ADMINISTRATION HOSPITAL                   |  | d. STREET ADDRESS   |  | WAUGH CHAPEL ROAD   |  |  |  |  |  |   |  |                  |  |
| 3. NAME OF DECEASED<br>(Type or print)   |  | First  |  | Middle  |  | Last  |  | 4. DATE OF DEATH   |  | Month  |  | Day   |  | Year             |  |
|  |  | JEREMIAH   |  | (NMI)   |  | KIAH  |  | OCTOBER  |  | 10,  |  | 19  |  | 56               |  |
| 5. SEX   |  | 6. COLOR OR RACE                                   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                     |  | 8. DATE OF BIRTH  |  | 9. AGE (In years last birthday)  |  | IF UNDER 1 YEAR                              |  | IF UNDER 24 HRS.  |  |                  |  |
| MALE   |  | NEGRO  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 10-22-92  |  | 63 yrs.  |  | Months                                       |  | Days  |  | Hours            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | LABORER  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | JANITOR, PLASTIC CO   |  | 11. BIRTHPLACE (State or foreign country)  |  | CAMBRIDGE, MARYLAND                          |  | 12. CITIZEN OF WHAT COUNTRY?  |  | U.S.A.           |  |
| 13. FATHER'S NAME  |  | JOHN KIAH  |  | 14. MOTHER'S MAIDEN NAME  |  | JULIA MYSTER  |  |  |  |  |  |   |  |                  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |  | YES  |  | 16. SOCIAL SECURITY NO.   |  | 218-10-2887   |  | 17. INFORMANT  |  | CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD. |  |   |  |                  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA, RIGHT LUNG WITH GENERALIZED METASTASIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DOES NOT</u><br>DUE TO (c) <u>UNKNOWN</u> |  |  |  |   |  |   |  |  |  |  |  |   |  |                  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)               |  |   |  |  |  |  |  |   |  |                  |  |
| 20c. TIME OF INJURY<br>Hour a. p. m. 19  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  |   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)           |  |  |  | 20f. (City or town)   |  | (County) (State) |  |
| 21. I certify that A attended the deceased from July 16, 1956, to Oct. 10, 1956, and that death occurred at 6:05 P.M. from the causes and on the date stated above.  |  |  |  |   |  |   |  |  |  |  |  |   |  |                  |  |
| ACTUAL SIGNATURE   |  | IRVING FREEMAN                                     |  | M.D.  |  | VAH, FORT HOWARD, MARYLAND  |  | DATE SIGNED  |  | 10/11/56                                     |  |   |  |                  |  |
| PHYSICIAN'S NAME (Type)  |  | IRVING FREEMAN, M.D.                               |  |   |  |   |  |  |  |  |  |   |  |                  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | BURIAL   |  | 22b. DATE THEREOF   |  | 10/15/56  |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | BALTIMORE NATIONAL                           |  | 22d. LOCATION (City, town, or county)   |  | (State)          |  |
|  |  |  |  |   |  |   |  |  |  |  |  | BALTIMORE MARYLAND  |  |                  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE   |  | CHARLES R LAW MORTUARY 802-04 MADISON AVE BALTO MD |  | ADDRESS   |  |   |  | 24a. REC'D BY REGISTRAR  |  | 24b. REGISTRAR'S SIGNATURE                   |  | DATE  |  | 01.15.56         |  |

VS A15 (4)  
15M 9/55

RECEIVED

OCT 17 1956

BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10040

10062

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <b>VIRGINIA</b> b. COUNTY                                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>MIDDLE RIVER</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>PARKSLEY</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   | d. STREET ADDRESS   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BEULAH</b> Middle Last <b>KILLMON</b>   |   | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>12</b> Year <b>19 56</b>  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>DEC. 15, 1893</b>  |
| 9. AGE (In years last birthday) <b>62</b> yrs   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>*****</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>PARKSLEY, VIRGINIA</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>JOHN WILLIAM ONLEY</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>HENRIETTA NORTHAM</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>MR. NOAH KILLOM</b>   |   | Address<br><b>PARKSLEY, VIRGINIA.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF BREAST</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yr</b>    |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>Sept. 19, 1956</b> to <b>Oct. 12, 1956</b> that I last saw the deceased alive on <b>Oct 4, 1956</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>805 FUSELAGE AVE, MIDDLE RIVER, MD.</b> DATE SIGNED |   |   |   |
| ACTUAL SIGNATURE <b>Marvin J. Rombro</b> M.D.   |   |   |   |
| PHYSICIAN'S NAME (Type) <b>MARVIN J. ROMBRO.</b>  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>   | 22b. DATE THEREOF<br><b>10-12-56</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>PARKSLEY BAPTIST</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>PARKSLEY, VIRGINIA.</b>                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Jickner</b>   |   | 24a. REC'D BY REGISTRAR<br><b>Wm. J. Jickner</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Wm. J. Jickner</b>   |

RECEIVED  
OCT 13 1956  
BUREAU



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10041

10063

CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Balto.</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY                                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>5743 Edmondson Ave.<br/>Ridgeway Manor Nurs. Ho.</b>  |   | d. STREET ADDRESS<br><b>3612 Woodbine Ave.</b>  |   |
| 3. NAME OF (Type or print)<br>First <b>JACOB</b> Middle <b>KING</b> Last   |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>3</b> Year <b>1956</b>   |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Apr. 1, 1874</b>                               |
| 9. AGE (In years last birthday)<br><b>82</b> yrs.  |   | IF UNDER 1 YEAR: Months <b>3</b> Days <b>19</b> Hours <b>56</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman (rtd)</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>Jacob King</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Jeannette (unknown)</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |   | 16. SOCIAL SECURITY NO.<br><b>213-03-35140</b>  |   |
| 17. INFORMANT<br><b>Mr. Charles Stallings</b>  |   | Address<br><b>3612 Woodbine Ave.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Insufficiency of Age</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Atherosclerosis</b><br>DUE TO<br>(c) |   |   | INTERVAL BETWEEN ONSET AND DEATH                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that I attended the deceased from <b>10-2</b> to <b>10-3</b> , 1956, that I last saw the deceased alive on <b>10-2</b> , 1956, and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.   |   |   |   |
| ACTUAL SIGNATURE<br><b>Dr. Thomas G. Abbott</b>  |   | ADDRESS (Street, city or town, state)<br><b>4509 Liberty Heights Ave., BALTO MD</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>DR THOMAS G ABBOTT</b>   |   | DATE SIGNED<br><b>10-5-56</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   | 22b. DATE THEREOF<br><b>10/6/56</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cem.</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Pickens &amp; Sons - Balto</b>   |   | ADDRESS<br><b>17th St. Balto</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>10/6/56</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>R-65</b>   |   |

MEDICAL CERTIFICATION

1954

9504

1954

## MARYLAND STATE DEPARTMENT OF HEALTH

10042

2411 N. Charles Street, Baltimore

10064

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

|  |                           |   |                                   |   |   |  |  |
|--|---------------------------|---|-----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>COUNTY Baltimore MARYLAND Md  |                           |   |                                   | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE Maryland COUNTY                  |   |  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town) Towson   |                           |   |                                   | CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore |   |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Mercy Villa  |                           |   |                                   | STREET ADDRESS (If rural, give location) Ambassador Apts                        |   |  |  |
| 3. NAME OF DECEASED<br>(Type or Print)   |                           | (First) Agnes (Middle) G. (Last) Kirby  |                                   | 4. DATE OF DEATH  |   | (Month) Oct. (Day) 30 (Year) 1956                            |  |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single   | 8. DATE OF BIRTH<br>Feb. 11, 1832 | 9. AGE last birthday<br>74 yrs.   | If under 1 year<br>Months Days Hours Min. | If under 24 hrs.<br>Hours Min.                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>None  |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |                                   | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Md                      |   | 12. CITIZEN OF WHAT COUNTRY?                                 |  |
| 13. FATHER'S NAME<br>Joseph H. Kirby   |                           |   |                                   | 14. MOTHER'S MAIDEN NAME<br>Mary FitzPatrick                                    |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                           |   |                                   | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Mr. Raymond A. Kirby 1927 Park Ave          |  |
| 18. MEDICAL CERTIFICATION  |                           |   |                                   |   |   |  |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                           |   |                                   |   |   | INTERVAL BETWEEN ONSET AND DEATH                             |  |
| 4. Immediate cause (a) Pneumonia, Anger, Heart Failure, Cerebral Vascular Accident, Hemiparesis  |                           |   |                                   |   |   | 2-3 days   |  |
| Antecedent cause(s) (b) Hypertension, Arterio-Sclerosis, stating the underlying cause last (c) Myocarditis   |                           |   |                                   |   |   | Gradual  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |                           |   |                                   |   |   |  |  |
| 19a. DATE OF OPERATION   |                           |   |                                   | 19b. MAJOR FINDINGS OF OPERATION  |   |  |  |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |                           |   |                                   |   |   |  |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)  |                           | PLACE (Home, farm, factory, street, OF office bldg., etc.)  |                                   | (CITY OR TOWN)  |   | (COUNTY) (STATE)   |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   |                           | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |                                   | HOW DID INJURY OCCUR?   |   |  |  |
| 22. I hereby certify that I attended the deceased from July, 1945 to Oct 30, 1956, that I last saw the deceased alive on Oct 30, 1956, and that death occurred at 8:45 P.m., from the causes and on the date stated above. |                           |   |                                   |   |   |  |  |
| SIGNATURE <i>W. H. Mearns</i>  |                           |   |                                   | ADDRESS   |   |  |  |
| 23. BURIAL, CREMATION REMOVAL (Specify)  |                           | DATE THEREOF Nov. 2, 1956   |                                   | NAME OF CEMETERY OR CREMATORY St. Mary's Govans                                 |   | LOCATION (City, town, or county) Baltimore, Maryland (State) |  |
| DATE REC'D BY LOCAL REG.   |                           | REGISTRAR'S SIGNATURE   |                                   | 24. FUNERAL DIRECTOR <i>W. H. Mearns &amp; Son</i> 805 N. Calvert St.           |   |  |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.



9974

## CERTIFICATE OF DEATH

Reg. Dist. No.

41

|  |                               |  |   |   |   |
|--|-------------------------------|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTO</u> MARYLAND   |                               |  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>MD</u> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>   |                               |  | c. LENGTH OF STAY IN 1b <u>2 YRS.</u>   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8219 DOGWOOD DRIVE</u>   |                               |  | d. STREET ADDRESS <u>#1</u>   |   |   |
| 3. NAME OF DECEASED (Type or print) <u>HARRY</u> First <u>FRANK</u> Middle <u>KLAUS</u> Last <u>SR.</u>  |                               |  | 4. DATE OF DEATH <u>10-19-56</u> Month <u>10</u> Day <u>19</u> Year <u>19</u>   |   |   |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN. 8, 1881</u>  |   | 9. AGE (In years last birthday) <u>75</u> yrs.                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSPECTOR</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>FLOOR COVERING</u>  |   | 11. BIRTHPLACE (State or foreign country) <u>PENNA</u>                          |   |
| 13. FATHER'S NAME <u>JACOB KLAUS</u>   |                               |  | 14. MOTHER'S MAIDEN NAME <u>MARY E. KELLER</u>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |                               | 16. SOCIAL SECURITY NO. <u>196-10-3166</u>   |   | 17. INFORMANT <u>MILDRED E. LOGAN</u> Address <u>311 BAYSIDE DR. DUNDALK 22</u> |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u><br>DUE TO (c) <u>Left hydronephrosis</u>             |                               |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>1953</u><br><u>1954</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)          |   |
| 20f. (City or town) (County) (State)   |                               |  |   |   |   |
| 21. I certify that I attended the deceased from <u>OCT 28, 1953</u> , to <u>OCT 19, 1956</u> , that I last saw the deceased alive on <u>OCT 19, 1956</u> , and that death occurred at <u>10:15 P.</u> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>7001 Mornington Rd. Dundalk, Md</u> DATE SIGNED <u>Oct 22 1956</u> |                               |  |   |   |   |
| ACTUAL <u>Eugene F Nery</u> M.D. <u>7001 Mornington Rd. Dundalk, Md</u>  |                               |  |   |   |   |
| PHYSICIAN'S NAME (Type) <u>Eugene F Nery M.D.</u>  |                               |  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                               | 22b. DATE THEREOF <u>10-22-56</u>  |   | 22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOSEPH'S</u>                          |   |
| 22d. LOCATION (City, town, or county) (State) <u>LANCASTER, PENNA</u>  |                               |  |   |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Park Boddy, Dundalk, Md.</u>  |                               |  | 24a. REC'D BY REGISTRAR <u>Oct 22 1956</u>  |   |   |
|  |                               |  | 24b. REGISTRAR'S SIGNATURE <u>Walter Park Boddy</u>   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low require that the death certificate be executed within 24 hours after death. Page 1

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 22 1956

BUREAU V. S.

10065

## CERTIFICATE OF DEATH

10044

Reg. Dist. No. 33

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Reisterstown Rural</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>48 years</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Pleasant Grove</u>   |                                  | e. STREET ADDRESS<br><u>Pleasant Grove</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>ROSA.</u> Middle <u>ANN</u> Last <u>KORMAN</u>  |                                  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>25</u> Year <u>1956</u>   |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>JANUARY 24, 1875</u> |
| 9. AGE (In years last birthday)<br><u>81</u> yrs.   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u>   |   |
| 13. FATHER'S NAME<br><u>William Brathburn</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Sophia Duce</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>none</u>  |   |
| 17. INFORMANT<br><u>Bessie KORMAN</u>   |                                  | Address<br><u>Reisterstown Md</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Myocarditis</u><br><u>H201</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO (c) _____ |                                  |   | INTERVAL BETWEEN ONSET AND DEATH            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                                  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>August 15, 1956</u> to <u>Oct 25, 1956</u> , that I last saw the deceased alive on <u>Oct 22, 1956</u> , and that death occurred at <u>9 A. M.</u> from the causes and on the date stated above.   |                                  |   |   |
| ACTUAL SIGNATURE<br><u>Joseph E. Bush</u>   |                                  | M.D. <u>Hampstead Md</u>  |   |
| PHYSICIAN'S NAME (Type)<br><u>Joseph E. Bush M.D.</u>   |                                  | <u>Hampstead Maryland</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>Oct 27-1956</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Pleasant Grove</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Balto Co Md</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Edw C Lipton</u>   |                                  | ADDRESS<br><u>Hampstead Md</u>  |   |
| 24a. REC'D BY REGISTRAR<br>DATE <u>10-26</u>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Mary B Elmer</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completed, may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and deliver them to the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM V. S.

OCT 2 1936

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9975

## CERTIFICATE OF DEATH

10045

Reg. Dist. No.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Dundalk</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Dundalk</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>8201 Long Point Road</u>  |   | d. STREET ADDRESS<br><u>8201 Long Point Road</u>   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>LOUIS</u> Middle <u>C.</u> Last <u>KURZMILLER</u>  |   | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>5</u> Year <u>19 56</u>  |  |
| 5 SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>DEC 3. 1902</u>                                 |
| 9. AGE (In years last birthday)<br><u>53</u> yrs.  |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Bethlehem Steel Co.</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>Charles Kurzmiller</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Antona Kreiner</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br>No.   |   | 16. SOCIAL SECURITY NO.<br><u>216-09-6761</u>  |  |
| 17. INFORMANT<br><u>Mrs. Alice Kurzmiller</u>  |   | Address<br><u>8201 Long Point Road</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>None</u><br>DUE TO (c) <u>None</u>   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hrs</u>                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>None</u>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                   |
| 21. I certify that I attended the deceased from <u>MARCH 4, 1955</u> to <u>OCT. 5, 1956</u> that I last saw the deceased alive on <u>OCT. 1, 1956</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><u>7773 Davis</u> M.D. <u>6800 MCKINNON RD</u><br>PHYSICIAN'S NAME (Type) <u>M B. DAVIS MD</u> <u>Dundalk - Md</u> <u>10/7/56</u> |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>Oct. 8, 1956</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Moreland Park</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>Parkville, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Ullrich Funeral Home</u>  |   | ADDRESS<br><u>2112 Dundalk Ave.</u>  |  |
| 24a. REC'D BY REGISTRAR<br>DATE <u>2-3-1959</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Wm P. Kelly</u>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1  
To be filed by the hospital or attending physician.  
To be filed by the funeral director: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers and file with the registrar.

RECEIVED

1956



1956

## CERTIFICATE OF DEATH

10046

10066

Reg. Dist. No. 1

|  |                  |  |                  |   |                 |  |                  |
|--|------------------|--|------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH  |                  |  |                  | 2. USUAL RESIDENCE (HOME) OF DECEASED                                 |                 |  |                  |
| COUNTY <u>BALTIMORE</u>  |                  | STATE <u>MD</u>  |                  | COUNTY  |                 |  |                  |
| CITY (If outside corporate limits, write RURAL OR end give nearest town)   |                  | LENGTH OF STAY (in this place)   |                  | CITY (If outside corporate limits, write RURAL and give nearest town) |                 | OR TOWN  |                  |
| TOWN <u>COCKEYSVILLE</u>   |                  | <u>17 YEARS</u>  |                  | TOWN <u>EASTON</u>  |                 |  |                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>  |                  |  |                  | STREET ADDRESS (If rural give location)                               |                 |  |                  |
| 3. NAME OF DECEASED (Type or Print)  |                  |  |                  | 4. DATE OF DEATH  |                 |  |                  |
| (First) <u>HARVEY</u> (Middle) <u>LEONARD</u> (Last)   |                  |  |                  | (Month) <u>10</u> (Day) <u>1</u> (Year) <u>1956</u>                   |                 |  |                  |
| 5. SEX   | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)   | 8. DATE OF BIRTH | 9. AGE last birthday  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS. |
| <u>M</u>   | <u>W</u>         | <u>WIDOWED</u>   | <u>9/28/1873</u> | <u>83</u> yrs.  | Months          | Days   | Hours Min.       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                  | 10b. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)                             |                 | 12. CITIZEN OF WHAT COUNTRY?                             |                  |
| <u>DENTIST</u>   |                  |  |                  | <u>TALBOT COUNTY, MD</u>  |                 | <u>U.S.</u>  |                  |
| 13. FATHER'S NAME  |                  |  |                  | 14. MOTHER'S MAIDEN NAME  |                 |  |                  |
| <u>JONATHAN HADAWAY LEONARD</u>  |                  |  |                  | <u>ANNA MATILDA NEUMAN</u>  |                 |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)  |                  | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT'S NAME & ADDRESS  |                 |  |                  |
| <u>NO</u>  |                  | <u>NONE</u>  |                  | <u>Frank L. Smith Jr. Cockeysville, Md</u>                            |                 |  |                  |
| 18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                  |  |                  | 19. MEDICAL CERTIFICATION   |                 |  |                  |
| IMMEDIATE CAUSE (A)  |                  |  |                  | INTERVAL BETWEEN ONSET AND DEATH                                      |                 |  |                  |
| ANTECEDENT CAUSE(S) DUE TO   |                  |  |                  | <u>Arterio-sclerotic Cardio Vascular Disease</u>                      |                 |  |                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE   |                  |  |                  |   |                 |  |                  |
| STATING UNDERLYING CAUSE LAST. DUE TO  |                  |  |                  |   |                 |  |                  |
| (C)  |                  |  |                  |   |                 |  |                  |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                  |  |                  |   |                 |  |                  |
| 19a. DATE OF OPERATION   |                  | 19b. MAJOR FINDINGS OF OPERATION   |                  | 20. AUTOPSY?  |                 | YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |                  | 21c. WHERE DID INJURY OCCUR? (City or town)                           |                 | (County) (State)   |                  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |                  | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                  | 21f. HOW DID INJURY OCCUR?  |                 |  |                  |
| 22. I hereby certify that I attended the deceased from <u>1/28</u> , 19 <u>47</u> , to <u>10/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/1</u> , 19 <u>56</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above. |                  |  |                  |   |                 |  |                  |
| SIGNATURE  |                  | ADDRESS (Street, city, town, state)  |                  | DATE SIGNED   |                 |  |                  |
| <u>Walter T. Lees</u>  |                  | <u>Cockeysville, Md.</u>   |                  | <u>10/1/56</u>  |                 |  |                  |
| 23. BURIAL, CREMATION, REMOVAL, (SPECIFY)  |                  | DATE THEREOF   |                  | NAME OF CEMETERY OR CREMATORY   |                 | LOCATION (City, town, or county) (State)                 |                  |
| <u>BURIAL</u>  |                  | <u>10-4-56</u>   |                  | <u>SPRING HILL CEM.</u>   |                 | <u>EASTON, MARYLAND</u>                                  |                  |
| 24. REC'D BY REGISTRAR   |                  | REGISTRAR'S SIGNATURE  |                  | 25. FUNERAL DIRECTOR'S SIGNATURE                                      |                 | ADDRESS  |                  |
| DATE <u>OCT 4 1956</u>   |                  | <u>William Cook, Jr.</u>   |                  | <u>1517 ST. PAUL ST.</u>  |                 |  |                  |

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. A bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

J. W. E.

95

15/1

10062

VS. A15ME(S)  
SM 9/55

U.S. AIR

CT 30 1956

RECEIVED

may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4  
 REGISTRATION: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9934

CERTIFICATE OF DEATH

10048

Reg. Dist. No.

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>APOTHECARY</u>   |  | c. LENGTH OF STAY IN 1b   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  | d. STREET ADDRESS<br><u>732 Beechfield Avenue</u>   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Howard W. Lewis</u>   |  | 4. DATE OF DEATH Month Day Year<br><u>Oct 11, 1956</u>  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 9, 1903</u>                                     |
| 9. AGE (In years last birthday) yrs<br><u>53</u>  |  | IF UNDER 1 YEAR Months Days Hours Min.  | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>sewist</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |   |
| 13. FATHER'S NAME<br><u>Louis Doering</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Barbara S. Linder</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br><u>16-07-2411</u>  |   |
| 17. INFORMANT Address<br><u>Howard W. Lewis 732 Beechfield Avenue</u>   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO (b) <u>Coronary artery disease</u><br>DUE TO (c) <u>lying cause last.</u>      |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1.2 hours</u><br><u>1 yr.</u>        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>Sept 10, 1956</u> to <u>Oct 10, 1956</u> , that I last saw the deceased alive on <u>Oct 10, 1956</u> , and that death occurred at <u>8:10 A.M.</u> from the causes and on the date stated above. |  |   |   |
| ACTUAL SIGNATURE <u>Earl Pass M.D.</u>  |  | DATE SIGNED <u>Oct 11, 1956</u>   |   |
| PHYSICIAN'S NAME (Type) <u>I. EARL PASS, M.D.</u>   |  | <u>Back 29, 1919.</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 22b. DATE THEREOF<br><u>10/13/56</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Holy Redeemer Cemetery</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>Howard W. Lewis 732 Beechfield Avenue</u>  |  | 24a. REC'D BY REGISTRAR<br><u>DATE 10/15/56</u>   | 24b. REGISTRAR'S SIGNATURE  |

BUREAU V. S.

OCT 10 1900

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10049

10068

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

|  |                                  |   |  |   |   |  |  |
|--|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>   |                                  |   |  | c. LENGTH OF STAY IN b<br><b>6 Days</b>   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Veterans Administration Hospital</b>  |                                  |   |  | e. STREET ADDRESS<br><b>3921 Norfolk Avenue</b>   |   |  |  |
| 3. NAME OF DECEASED (Type or print) <b>JAKE</b> First Middle Last <b>M. LIBERMAN</b>   |                                  |   |  | 4. DATE OF DEATH <b>October 22</b> Month Day Year <b>1956</b>   |   |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 22, 1892</b> |   | 9. AGE (In years last birthday)<br><b>64</b> yrs. | IF UNDER 1 YEAR: Months Days Hours Min.<br>IF UNDER 24 HRS: Months Days Hours Min.             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Merchant</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Clothing Business</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Ponevez, Russia</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 13. FATHER'S NAME<br><b>Harry Liberman</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO<br><b>Unknown</b>  |  | 17. INFORMANT Address<br><b>Clin. Rec., Vet. Adm. Hospital, Fort Howard, Maryland</b>                                       |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BRONCHOPNEUMONIA</b><br>DUE TO<br>(c) |                                  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 MONTHS</b><br><b>8 DAYS</b>                           |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>    |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>October 16, 1956</b> to <b>October 22, 1956</b> and that death occurred at <b>1:30 P. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>VAH, FORT HOWARD, MARYLAND 10/22/56</b>                     |                                  |   |  |   |   |  |  |
| ACTUAL SIGNATURE <b>C. J. Papastrat MD</b>   |                                  |   |  | PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M.D.</b>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>10-23-56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hebrew Cemetery - Windsor Hill Rd</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Jack Lewis, Inc., 2100 Eutaw Pl., Balto., Md.</b>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br><b>DATE 24 1956</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Lawson L. Parker</b>  |  |

BUREAU A. S.

9501 100

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10069 CERTIFICATE OF DEATH

10050

Reg. Dist. No. 20

|   |                                  |   |  |  |   |  |   |
|---|----------------------------------|---|--|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |                                  |   |  | c. LENGTH OF STAY IN 1b<br><b>1mth5days</b>  |   |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>SPRING GROVE STATE HOSPITAL</b>   |                                  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Frederick W. Link</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>18</b> Year <b>19 56</b>   |   |  |   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 16, 1884</b> |  | 9. AGE (In years lost birthday)<br><b>71</b> yrs. | 10. IF UNDER 1 YEAR<br>Months Days Hours Min                           |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>unknown</b>   |                                  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>           |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                  |   |  |  |   |  |   |
| 13. FATHER'S NAME<br><b>Adam Link</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lizzie Lacombe</b>  |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>unknown</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |  | 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) <b>Myocardial infarction</b><br>DUE TO (c) <b>Coronary and generalized arteriosclerosis</b> |                                  |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b><br><b>1 mth.</b><br><b>years</b>               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Pulmonary emphysema</b>   |                                  |   |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. <b>19</b>   |                                  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                    |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
|   |                                  |   |  | 20f. (City or town) (County) (State)   |   |  |   |
| 21. I certify that I attended the deceased from <b>Sept. 13, 19 56</b> to <b>October 18, 19 56</b> , that I last saw the deceased alive on <b>Oct. 18, 19 56</b> , and that death occurred at <b>8:30 a.m.</b> , from the causes and on the date stated above.  |                                  |   |  |  |   |  |   |
| ACTUAL SIGNATURE<br><i>Charles S. Ward</i>  |                                  |   |  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>SPRING GROVE STATE HOSPITAL 10-18-56</b>   |   |  |   |
| PHYSICIAN'S NAME (Type)<br><b>Charles S. Ward, M. D.</b>  |                                  |   |  | <b>Catonsville 28, Maryland</b>  |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10/20/56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>     |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Wm. J. Pickner &amp; Sons - Balto.</i>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>22 1956</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                       |   |

RECEIVED  
OCT 22 1956  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10070

## CERTIFICATE OF DEATH

10051

Reg. Dist. No.

37

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Warren Road</u>  |                               | d. STREET ADDRESS <u>Warren Road</u>   |   |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>H.</u> Last <u>Lintz</u>   |                               | 4. DATE OF DEATH Month <u>October</u> Day <u>13</u> Year <u>1956</u>   |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 4, 1881</u>            |
| 9. AGE (In years last birthday) <u>74</u> yrs  |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |   |
| 13. FATHER'S NAME <u>Jacob Class</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Augusta Stern</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <u>None</u>  |   |
| 17. INFORMANT <u>W. Ross Lintz</u>   |                               | Address <u>Warren Rd. Cockeysville, Md.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><u>420.1</u> DUE TO <u>Coronary Occlusion</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis</u><br>(c) <u>none</u> |                               |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>1956</u> , that I last saw the deceased alive on <u>13 Oct</u> , 19 <u>56</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.  |                               |  |   |
| ACTUAL SIGNATURE <u>Charles H. Kenna</u>   |                               | ADDRESS (Street, city or town, state) <u>6701 York Rd</u> DATE SIGNED <u>15 Oct 56</u>   |   |
| PHYSICIAN'S NAME (Type)  |                               |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 22b. DATE THEREOF <u>Oct. 16, 1956</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Jacksonville Reformed</u>  |                               | 22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Largan Funeral Home</u>  |                               | ADDRESS <u>7401 Oakview Rd.</u>  |   |
| 24a. REC'D BY REGISTRAR <u>DATE 11/1956</u>  |                               | 24b. REGISTRAR'S SIGNATURE <u>Anne MacL...</u>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in pages 1 and 2, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return pages 1 and 2 to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. A. OVERVIEW

DECEMBER 1964

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10052

10071

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>COUNTY <u>Balto.</u> MARYLAND   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Md.</u> COUNTY  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Raspburg</u>                               |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Kenwood</u>                   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>5113 Kenwood Ave</u>   |  | STREET ADDRESS (If rural, give location)<br><u>5113 Kenwood Ave</u>                                       |  |
| 3. NAME OF DECEASED<br>(Type or Print)   | (First) <u>Joseph</u> (Middle) <u>(Giuseppe)</u> (Last) <u>Mancano</u> | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Oct 28 1956</u>   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>                                       | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>Married</u>  | 8. DATE OF BIRTH<br><u>Apr 16 1891</u> |
| 9. AGE last birthday<br><u>65</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Cook</u> |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Italy</u>  |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>John Mancano</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Angelina Parisi</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)<br><u>No</u> |  | 16. SOCIAL SECURITY No.<br><u>218-32-1011</u>   |  |
| 17. INFORMANT AND ADDRESS<br><u>Angelina Mancano 5113 Kenwood</u>  |  |   |  |

|   |  |   |                                  |
|---|--|---|----------------------------------|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  | 18. MEDICAL CERTIFICATION   | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause (a) <u>Heart attack - arterial C.V.D. - 1/2 hr</u>  |  |   |                                  |
| Antecedent cause(s) (b) _____   |  |   |                                  |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____                          |  |   |                                  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |   |                                  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION  |                                  |
| 21. ACCIDENT (Specify)<br>SUICIDE<br>HOMICIDE   |  | PLACE (Home, farm, factory, street, office bldg., etc.)<br>INJURY                                 |                                  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |                                  |
|   |  | HOW DID INJURY OCCUR?   |                                  |

22. I hereby certify that I attended the deceased from home, 1956, to 10/28, 1956, that I last saw the deceased alive on 10/25, 1956, and that death occurred at 2:50 p.m., from the causes and on the date stated above.

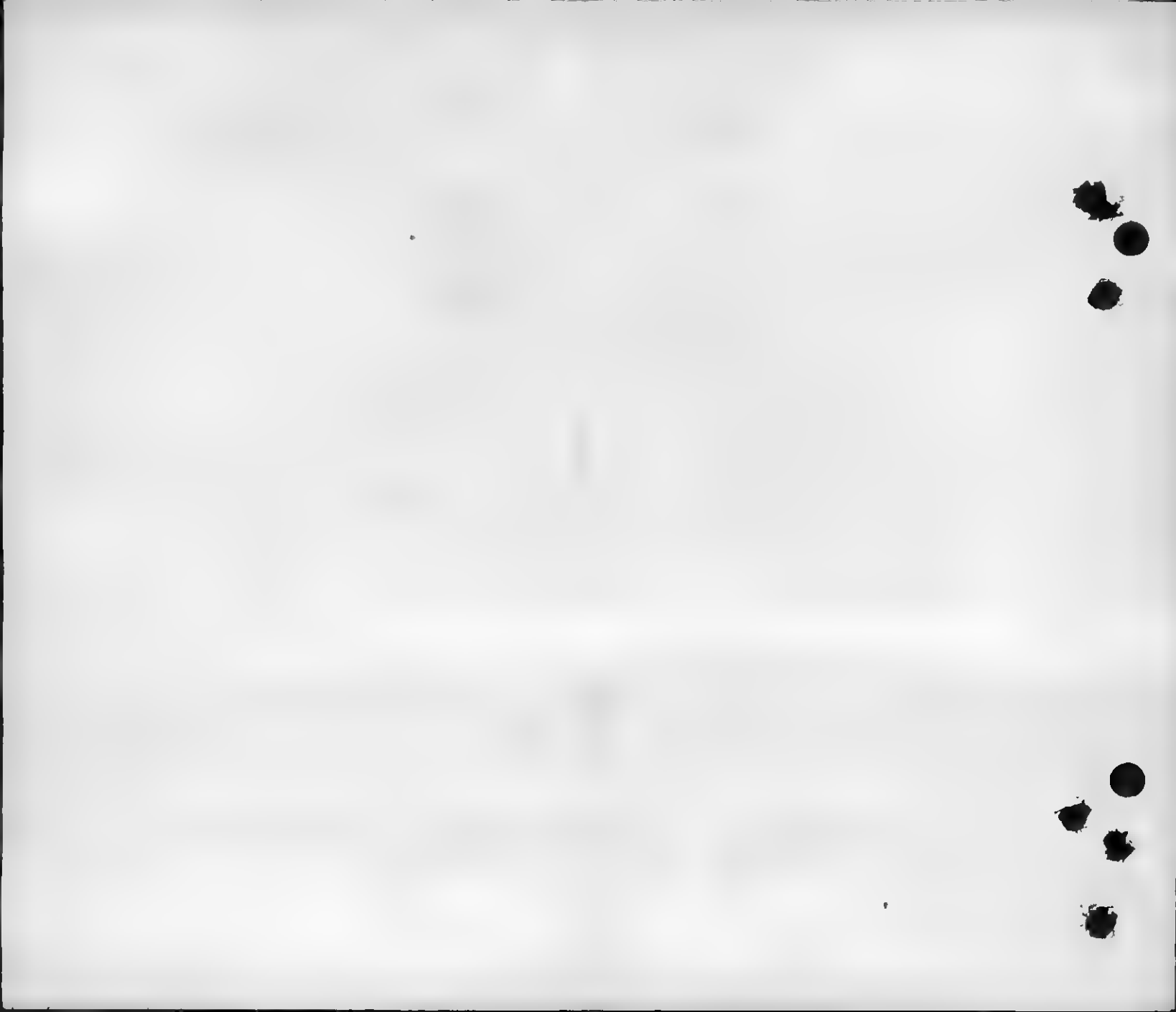
SIGNATURE E. J. [Signature] ADDRESS 829 [Address] DATE SIGNED 11/29/56

|   |                            |  |  |
|---|----------------------------|--|--|
| 23. BURIAL CREMATION REMOVAL (Specify)<br><u>BURIAL</u> | DATE<br><u>OCT 31 1956</u> | NAME OF CEMETERY OR CREMATORY<br><u>PARKWOOD CEMETERY</u>          | LOCATION (City, town, or county) (State)<br><u>TAYLOR AVE MD</u> |
| DATE REC'D BY LOCAL REG.                                | REGISTRAR'S SIGNATURE      | 24. FUNERAL DIRECTOR ADDRESS<br><u>Shippin Bldg 7110 BELAIR RD</u> |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A





10072

CERTIFICATE OF DEATH

10053

Reg. Dist. No.

30

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY                                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>1yr11mt25dys</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SPRING GROVE STATE HOSPITAL</b>  |                                  | e. STREET ADDRESS<br><b>Altamont Hotel - Eutaw &amp; Lanvale Sts.</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ida</b> Middle <b>Mae</b> Last <b>Marshall</b>  |                                  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>29</b> Year <b>1956</b>   |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 8, 1882</b> |
| 9. AGE (In years last birthday)<br><b>74</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 13. FATHER'S NAME<br><b>James F. Johnson</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Sally Elizabeth Tull</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>—</b>   |   |
| 17. INFORMANT<br>Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |                                  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Senility</b><br>DUE TO<br>(c) <b>Dehydration</b>                              |                                  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Debility - Decubital sores</b>  |                                  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Oct. 3, 1956</b> to <b>Oct. 29, 1956</b> , that I last saw the deceased alive on <b>Oct. 29, 1956</b> , and that death occurred at <b>8:30a M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL 10-29-56</b> |                                  |   |   |
| ACTUAL SIGNATURE<br><b>Stella Wachslar</b>  |                                  | PHYSICIAN'S NAME (Type)<br><b>Stella Wachslar, M. D.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>11/1/56</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Episcopal Cem.</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Pocomoke City, Md.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Lickner &amp; Sons - Balt 17 Md</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>DATE Oct. 30, 1956</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>T. E. Harvey</b>   |                                  |   |   |

PUBLICITY A. 1

OCT 31 1956

RECEIVED  
OCT 31 1956

## Reg. Dist. No.

10073

### MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it may be returned by the hospital or attending physician. The funeral director, who is to fill in page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 21 1940

RECEIVED

## CERTIFICATE OF DEATH

10055 31

Reg. Dist. No.

10074

|  |                           |  |  |  |                                       |   |                 |
|--|---------------------------|--|--|--|---------------------------------------|---|-----------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTO.</b> MARYLAND  |                           |  |  | 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>Balto</b> |                                       |   |                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - RANDALLSTOWN</b>   |                           |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - RANDALLSTOWN</b>                       |                                       |   |                 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MCDONOUGH RD</b>   |                           |  |  | d. STREET ADDRESS <b>MCDONOUGH RD.</b>   |                                       |   |                 |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM STEWART MCCABE</b>  |                           |  |  | 4. DATE OF DEATH Month Day Year <b>10 3 1956</b>   |                                       |   |                 |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>APRIL 16, 1928</b> | 9. AGE (In years last birthday) <b>28</b> yrs  | IF UNDER 1 YEAR Months Days Hours Min |   | IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIELD ENGINEER</b>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <b>FIELD ENGINEER</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>OHIO</b>  |                                       | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |                 |
| 13. FATHER'S NAME <b>WILLIAM STANFORD MCCABE</b>   |                           |  |  | 14. MOTHER'S MAIDEN NAME <b>DOROTHY CHIDLOW</b>  |                                       |   |                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> (If yes, give year or date of service) <b>1948-1953</b>   |                           | 16. SOCIAL SECURITY NO. <b>212-269773</b>  |  | 17. INFORMANT <b>MOTHER DOROTHY MCCABE</b>   |                                       | Address <b>MCDONOUGH RD RANDALLSTOWN</b>  |                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF COLON</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>C</b><br>DUE TO<br>(c) |                           |  |  |  |                                       | INTERVAL BETWEEN ONSET AND DEATH <b>15 MONTHS</b>                                   |                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           |  |  |  |                                       | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                       |                                       |   |                 |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                       | 20f. (City or town) (County) (State)  |                 |
| 21. I certify that I attended the deceased from <b>August 17, 1954</b> , to <b>Oct. 3, 1956</b> , that I last saw the deceased alive on <b>Oct. 2, 1956</b> , and that death occurred at <b>10:45 A.M.</b> , from the causes and on the date stated above.   |                           |  |  |  |                                       |   |                 |
| ACTUAL SIGNATURE <b>Edwin L. Pierpont</b>  |                           |  |  | ADDRESS (Street, city or town, state) <b>8204 LIBERTY RD., BALTO. 7, MD.</b>   |                                       |   |                 |
| PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, M.D.</b>   |                           |  |  | DATE SIGNED <b>10/3/56</b>   |                                       |   |                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                           | 22b. DATE THEREOF  |  | 22c. NAME OF CEMETERY OR CREMATORY   |                                       | 22d. LOCATION (City, town, or county) (State)                                       |                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE   |                           |  |  | ADDRESS  |                                       |   |                 |
| 24a. REC'D BY REGISTRAR  |                           |  |  | 24b. REGISTRAR'S SIGNATURE   |                                       |   |                 |

BRITISH V. S.

CT 5 1956

REC-107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please move carbon papers, pages 1 and 2, to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10075

## CERTIFICATE OF DEATH

10056

Reg. Dist. No.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>                     |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |  |  |  | c. LENGTH OF STAY IN 1b  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Dulaney Valley Apts-900 Southerly Rd.</b>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>JAMES N. McCOSH, Sr.</b>  |  |  |  | 4. DATE OF DEATH Month Day Year<br><b>Oct. 4, 1956</b>   |  |  |   |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>white</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Apr. 6, 1881</b>                                |   |
| 9. AGE (In years last birthday)<br><b>75</b> yrs.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman (rtd)</b>                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Lumber</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Georgia</b>            |   |
| 12. CITIZEN OF WHAT COUNTRY?  |  |  |  |  |  |  |   |
| 13. FATHER'S NAME<br><b>Dr. Samuel A. McCosh</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Louise Kellog</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>215-18-5646</b>   |  | 17. INFORMANT Address<br><b>Mrs. James N. McCosh, Sr. - 900 Southerly Rd.</b>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ANAPLASTIC CARCINOMA Prostate</b><br>DUE TO (c) <b>Dec 1954</b> |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                   |   |
| 21. I certify that I attended the deceased from <b>JUNE</b> , 1951, to <b>4 Oct</b> , 1956, that I last saw the deceased alive on <b>2 October</b> , 1956, and that death occurred at <b>12:10 AM</b> , from the causes and on the date stated above.   |  |  |  |  |  |  |   |
| ACTUAL SIGNATURE <b>W. Kennedy Waller</b> M.D.  |  |  |  | ADDRESS (Street, city or town, state) <b>514 Cathedral St.</b> DATE SIGNED <b>5 Oct 1956</b>   |  |  |   |
| PHYSICIAN'S NAME (Type) <b>W. Kennedy Waller, M.D.</b>  |  |  |  |  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |  | 22b. DATE THEREOF<br><b>10/6/56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Wm. J. Lickner &amp; Sons - Balto 17 Md</b>  |  |  |  | 24a. REC'D BY REGISTRAR<br><b>Oct 2, 1956</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>R. W. Miller</b>                      |   |

U.S. AIR FORCE

1950

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10057

Reg. Dist. No.

10076

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Balto.</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>                          |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Marriotsville</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Marriotsville</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>R. F. D. #1</b>  |  |   |  | d. STREET ADDRESS<br><b>R. F. D. #1</b>   |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARY</b> Middle <b>MAY</b> Last <b>MENTZELL</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>18</b> Year <b>19 56</b>   |  |  |  |
| 5. SEX<br><b>female</b>   |  | 6. COLOR OR RACE<br><b>white</b>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Mar. 1, 1893</b>                                |  |
| 9. AGE (In years last birthday)<br><b>63</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS<br>Months Days Hours Min.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>? Ewing</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  | 17. INFORMANT<br><b>Mr. Lemuel K. Mentzell-R.F.D.#1, Marriotsville</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of uterus</b><br><b>1744X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>not known</b><br>DUE TO (c) |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>not known</b>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)   |  |   |  | 20g. (County)   |  | 20h. (State)   |  |
| 21. I certify that I attended the deceased from <b>Oct. 1st</b> , 19 <b>56</b> , to <b>Oct. 18</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Oct. 17</b> , 19 <b>56</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.                                    |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Wm. E. Martin</b>   |  |   |  | ADDRESS (Street, city or town, state) <b>Randallstown</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Wm. E. MARTIN</b>  |  |   |  | DATE SIGNED <b>md</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>10/22/56</b>      |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cem.</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>     |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Schaner &amp; Sons - Balto. Md.</b>   |  |   |  | ADDRESS   |  | 24a. REC'D BY REGISTRAR<br><b>DATE Oct. 22, 1956</b>                   |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Dr. Wm. E. Martin</b>  |  |  |  |

BUREAU K. B.

OCT 23 1956

RECEIVED  
OCT 23 1956  
FBI - NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 12 Film 06 11-5-56  
10077 CERTIFICATE OF DEATH

Reg. Dht. No. 10058 38

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY                               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armcast Nursing Home</u>  |  |  |  | d. STREET ADDRESS <u>5111 Plainfield Avenue</u>  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Mrs. Mary U Milan</u>   |  |  |  | 4. DATE OF DEATH Month Day Year<br><u>October 29th 1956</u>  |  |  |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>white</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>March 21, 1881</u>                                   |  |
| 9. AGE (In years last birthday) <u>75</u> yrs   |  | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  | 13. FATHER'S NAME <u>?</u>   |  | 14. MOTHER'S MAIDEN NAME <u>?</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address<br><u>Mr. Matthew J. Milan, 5111 Plainfield Ave</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia, left lower lobar (terminal)</u><br><u>450.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrene, 3rd &amp; 4th toes left foot</u><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                     |  |
| 21. I certify that I attended the deceased from <u>Sept 1, 1956</u> to <u>Oct 29, 1956</u> that I last saw the deceased alive on <u>Oct 26, 1956</u> and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>5101 Belair Rd</u> DATE SIGNED <u>10/30/56</u>  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Charles V Sevcik</u> M.D.   |  | PHYSICIAN'S NAME (Type) <u>Charles V Sevcik</u>  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>10/31/56</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>  |  |  |  | 24a. REC'D BY REGISTRAR <u>NOV - 1 1956</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Paul Hays</u>                              |  |

BUREAU V. S.

NOV 1 1956

RECEIVED

10078

## CERTIFICATE OF DEATH

Reg. Dist. No.

33-

|   |                               |  |                                       |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>             |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>  |                               | c. LENGTH OF STAY IN IB <u>66yrs.</u>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakland Rd.</u>   |                               | d. STREET ADDRESS <u>Oakland</u>   |                                       |
| 3. NAME OF DECEASED (Type or print) <u>Estelle L. Miller</u>  |                               | 4. DATE OF DEATH <u>October 23 1956</u>  |                                       |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 12, 1890</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - Own Home</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>  |                                       |
| 13. FATHER'S NAME <u>Charles Morris</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Julia Morris</u>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>—</u>   |                                       |
| 17. INFORMANT <u>Mrs. John Keeney, Freeland, Md. R.D.</u>   |                               | Address  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u><br>DUE TO (c) <u>—</u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that I attended the deceased from <u>Oct. 18</u> , 1956, to <u>Oct. 23</u> , 1956, that I last saw the deceased alive on <u>Oct. 22</u> , 1956, and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above.   |                               |  |                                       |
| ACTUAL SIGNATURE <u>G. M. France</u> M.D.   |                               | ADDRESS (Street, city or town, state) <u>Parkton, Md.</u> DATE SIGNED <u>12/25/56</u>  |                                       |
| PHYSICIAN'S NAME (Type) <u>Dr. A. M. France</u>   |                               | <u>Parkton, Md.</u>  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>Oct. 26, 1956</u>   |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>   |                               | 22d. LOCATION (City, town, or county) (State) <u>Freeland Md.</u>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>   |                               | ADDRESS <u>New Freedom, Pa.</u>  |                                       |
| 24a. REC'D BY REGISTRAR <u>—</u>  |                               | 24b. REGISTRAR'S SIGNATURE <u>Robert L. Burton</u>   |                                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9976 CERTIFICATE OF DEATH

1006041

Reg. Dist. No.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>BALTO.</u> MARYLAND   |  |   |  | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>                       |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>DUNDALK</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>15</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>6906 SOLLERS POINT Rd.</u>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3 NAME OF DECEASED<br>(Type or print) <u>MARY SANDNER MINNICK</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>OCT.</u> Day <u>1</u> Year <u>1956</u>  |  |  |  |
| 5. SEX <u>FEMALE</u>   |  | 6. COLOR OR RACE <u>WHITE</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>MAY 8, 1873</u>   |  |
| 9. AGE (In years last birthday) <u>83</u> yn   |  | IF UNDER 1 YEAR<br>Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>                             |  | IF UNDER 24 HRS<br>Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>MD.</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |   |  |  |  |  |  |
| 13. FATHER'S NAME <u>JOSEPH SANDNER</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>JOHANNA MEYERS</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>  |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |  | 17. INFORMANT<br><u>FRANK MINNICK - 46 BROADSHIP</u> Address <u>DUNDALK MD.</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cholecystitis and Hepatitis</u><br>DUE TO <u>—</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u><br>DUE TO <u>—</u><br>(c) <u>—</u> |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>70 days.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)<br><u>—</u>  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>—</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>—</u>   |  | 20f. (City or town) (County) (State)<br><u>—</u>   |  |
| 21. I certify that I attended the deceased from <u>Sept. 10, 1956</u> to <u>Oct. 1, 1956</u> , that I last saw the deceased alive on <u>Sept. 30, 1956</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><u>M.B. Davis</u>  |  |   |  | ADDRESS (Street, city or town, state)<br><u>6800 MORNINGTON RD BALTO. CO., MD.</u>   |  |  |  |
| PHYSICIAN'S NAME (Type)<br><u>M.B. DAVIS M.D.</u>  |  |   |  | DATE SIGNED<br><u>Sept. 27, 1956</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  | 22b. DATE THEREOF<br><u>10-4-56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>SACRED HEART OF J.</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>BALTO. CO., MD.</u>                        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Walter Charles Bradley, Dundalk, Md.</u>  |  |   |  | 24a. REC'D BY REGISTRAR<br><u>—</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>—</u>   |  |

BURTON V. S.

OCT 3 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.  
 MAY BE RETURNED TO THE HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completed, it may be returned to the hospital or attending physician. If it is not returned, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10061

10079

TEMS 13-21: G85 10-26-56L

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

|  |                                  |   |  |   |   |   |                                  |
|--|----------------------------------|---|--|---|---|---|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND.</b> b. COUNTY <b>BALTIMORE</b> |   |   |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>MIDDLE RIVER</b>  |                                  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>MIDDLE RIVER</b>                                       |   |   |                                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>442 WHITETHORN WAY</b>  |                                  |   |  | d. STREET ADDRESS<br><b>442 WHITETHORN WAY</b>  |   |   |                                  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>ALEXANDER STANLEY MOCARSKY</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>OCTOBER 24, 1956</b>   |   |   |                                  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>AUG. 16, 1902</b> | 9. AGE (In years last birthday)<br><b>54</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS.                 |
| 10a. USUAL OCCUPATION (Give kind of work done; during most of working life, even if retired)<br><b>HANDYMAN</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>MARTIN'S</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>HARTFORD CONN.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                 |                                  |
| 13. FATHER'S NAME<br><b>MOCARSKY</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME  |   |   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>215 07 4914</b>   |  | 17. INFORMANT<br><b>MRS FLORENCE A. MOCARSKY</b>  |   | Address<br><b>SAME.</b>   |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br><b>1420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart disease</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |                                  |
| 20c. TIME OF INJURY<br>Hour o. m. Month, Day, Year<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |                                  |
| 21. I certify that I attended the deceased from <b>Sept. 20</b> , 19 <b>56</b> , to <b>Oct. 24</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Oct. 24</b> , 19 <b>56</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED   |                                  |   |  |   |   |   |                                  |
| ACTUAL SIGNATURE<br><i>Hi Oktay</i><br>PHYSICIAN'S NAME (Type) <b>HI OKTAY</b>   |                                  |   |  | 100 N. Calhoun St.  |   |   |                                  |
| 22a. BURIAL, CREMATION, or other disposal (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>10/29/56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL CEM.</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>BALTIMORE MARYLAND.</b> |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>HENRY SANDER &amp; SONS INC BALTIMORE MD.</b>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>10/26/56</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><i>Edith Hurley</i>                           |                                  |

BUREAU V. S.

CT 1000

RECEIVED

28

## MEDICAL CERTIFICATION

VS A15 (4)  
ISM 9/55

U.S. DEPARTMENT OF JUSTICE

OCT 1960

RECEIVED

10081

## CERTIFICATE OF DEATH

10063 44  
Reg. Dist. No.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY                                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Fort Howard</u>  |   | c. LENGTH OF STAY IN 1b<br><u>34</u> days   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><u>Veterans Administration Hospital</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | d. STREET ADDRESS<br><u>307 E. Melrose Avenue</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>ROBERT</u> Middle <u>W</u> Last <u>MORAN</u>  |   | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>6</u> Year <u>1956</u>  |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>8/25/97</u>  |
| 9. AGE (In years last birthday)<br><u>59</u> yrs.   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Clerk</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Railroad</u>  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                      |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   | 13. FATHER'S NAME<br><u>Charles E. Moran</u>  |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Lillian M. Sullivan</u>  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>Yes</u> <u>WWII</u>                         |   |
| 16. SOCIAL SECURITY NO.<br><u>705-09-1356</u>   |   | 17. INFORMANT Address<br><u>Clin. Rec. Vets. Admin. Hosp., Ft. Howard, Md.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>FRESH THROMBOTIC OCCLUSION RIGHT ANTERIOR</u><br>DUE TO <u>CORONARY ARTERY</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>DUE TO (c)  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 HOURS</u><br><br><u>UNKNOWN</u>                          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>OLD HEALED APICAL MYOCARDIAL INFARCTION</u>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. ft. p. m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>September 2, 1956</u> , to <u>October 6, 1956</u> . The deceased was born <u>August 25, 1897</u> and that death occurred at <u>9:50 A.M.</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE <u>Arthur G. Edwards</u> M.D. <u>Veterans Administration Hospital</u><br>PHYSICIAN'S NAME (Type) <u>ARTHUR G. EDWARDS, M. D.</u> <u>Fort Howard, Md.</u> |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 22b. DATE THEREOF<br><u>10-11-56</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Parkwood Cemetery</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u>                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Henry U. Jenkins &amp; Sons, Inc.</u>  |   | 24a. REC'D BY REGISTRAR<br>DATE<br>24b. REGISTRAR'S SIGNATURE   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled, should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use in the burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

OCT 9 1956

RECEIVED

10082

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>42 Croftley Rd.</u><br><u>Baltimore County</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY                                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Lutherville</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore City</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>42 Croftley Road, Lutherville, Md.</u>  |  | d. STREET ADDRESS<br><u>318 E. 39th St</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br><u>Ada May Johnson Masberg</u>  |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>25</u> Year <u>1956</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>       | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov. 24 1889</u>                               |
| 9. AGE (In years last birthday)<br><u>66</u> yrs   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>-</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>Will. Solomon Johnson</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Amelia Adline Johnson</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO<br><u>None</u>   |   |
| 17. INFORMANT<br><u>Dr Wm. Masberg</u>   |  | Address <u>Baltimore</u><br><u>120 Hawthorne Rd. - 10</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Ca</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Carcinoma of Breast</u><br>DUE TO<br>(c) |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 yrs.</u>                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>-</u>  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br>19  |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>Sept 9, 1956</u> to <u>Oct 24, 1956</u> , that I last saw the deceased alive on <u>Oct 24, 1956</u> , and that death occurred at <u>10:15 P.</u> M, from the causes and on the date stated above.   |  |   |   |
| ACTUAL SIGNATURE<br><u>Lester A. Wall Jr.</u>  |  | ADDRESS (Street, city or town, state)<br><u>1039 St Paul St. Baltimore 2 Md</u>   |   |
| PHYSICIAN'S NAME (Type)<br><u>LESTER A. WALL JR.</u>   |  | DATE SIGNED<br><u>10/25/56</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>10-29-1956</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Lorraine Park</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Woodlawn, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>G Howard Strong</u>   |  | 24a. REC'D BY REGISTRAR<br>DATE: <u>3 10 56</u>   |   |
| ADDRESS<br><u>3207 W. North Ave</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Anna MacKay</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be accurate within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove portion pages 1 and 2 and send them to the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 1900

RECEIVED  
OCT 1900



10083

CERTIFICATE OF DEATH

10065

Reg. Dist. No.

|  |                                  |   |   |   |  |   |  |
|--|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>   |                                  |   |   | c. LENGTH OF STAY in 1b<br><b>55 Days</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Veterans Administration Hospital</b>   |                                  |   |   | d. STREET ADDRESS<br><b>104 North Greene Street</b>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HARRY</b> Middle <b>P.</b> Last <b>MULLEN</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>October 13,</b> Day <b>19</b> Year <b>56</b>   |  |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 3, 1895</b> |   | 9. AGE (In years last birthday) yrs<br><b>61</b> | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Operating Engineer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Civil Service</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Philadelphia, Pennsylvania</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                             |  |
| 13. FATHER'S NAME<br><b>Theodore Mullen</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Bage</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>577-14-9760</b>   |   | 17. INFORMANT<br><b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>1. Gastritis with hemorrhage 2. Renal Cortical Hemorrhages</b> |                                  |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>August 19, 1956</b> to <b>October 13, 1956</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>VAH, FORT HOWARD, MARYLAND 10/15/56</b>   |                                  |   |   |   |  |   |  |
| ACTUAL SIGNATURE <b>C. J. Papastrat MD</b>   |                                  |   |   | PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M.D.</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>10-17-56</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. Cook, Blight, Inc.</b>  |                                  |   |   | 24a. REC'D BY REGISTRAR<br><b>DATE</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Harold E. Loring</b>                       |  |

BUREAU V. S.

1956

RECEIVED

1

INSTRUCTIONS

The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10066

## 10084 CERTIFICATE OF DEATH

Reg. Dist. No. ....

|  |                              |  |  |  |   |   |                                |
|--|------------------------------|--|--|--|---|---|--------------------------------|
| 1. PLACE OF DEATH  |                              |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED  |   |   |                                |
| COUNTY <u>Balto.</u>   |                              | MARYLAND   |  | STATE <u>MD.</u>   |   | COUNTY <u>Balto.</u>  |                                |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Catonville</u>  |                              | LENGTH OF STAY<br>(In this place)                                      |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Catonville</u> |   |   |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>5632 Johnnycake Rd.</u>  |                              |  |  | STREET ADDRESS<br>(If rural give location)<br><u>5632 Johnnycake Rd.</u>                           |   |   |                                |
| 3. NAME OF DECEASED<br>(Type or Print) (First) (Middle) (Last)<br><u>Frank</u> <u>Mario</u>  |                              |  |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>Oct.</u> <u>11</u> <u>19 56</u>                     |   |   |                                |
| 5. SEX   | 6. COLOR OR RACE<br><u>Y</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>Married</u>     | 8. DATE OF BIRTH<br><u>Jan. 10, 1993</u> | 9. AGE last birthday<br><u>63</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours M.n. |   | IF UNDER 24 HRS.<br>Hours M.n. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Self. Emp.</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Fruit Produce</u>              |  | 11. BIRTHPLACE (State or foreign country)<br><u>Italy</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                       |                                |
| 13. FATHER'S NAME<br><u>Anthony Mario</u>  |                              |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Frances</u>   |   |   |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unk.)<br><u>NO</u>  |                              | 16. SOCIAL SECURITY NO.<br>(If Yes, give war or dates of service)      |  | 17. INFORMANT & ADDRESS<br><u>Mrs. James Dionio 5632 Johnnycake Rd.</u>                            |   |   |                                |
| 18. MEDICAL CERTIFICATION  |                              |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |                                |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                              |  |  |  |   |   |                                |
| IMMEDIATE CAUSE (A) <u>CARCINOMA RECTUM WITH</u>   |                              |  |  |  |   | <u>1 YR</u>   |                                |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>METASTASES TO LUNGS</u>  |                              |  |  |  |   | <u>2 Mos</u>  |                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)   |                              |  |  |  |   |   |                                |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                              |  |  |  |   |   |                                |
| 19a. DATE OF OPERATION<br><u>1/23/56</u>   |                              | 19b. MAJOR FINDINGS OF OPERATION<br><u>INOPERABLE CARCINOMA RECTUM</u> |  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                              | 21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.) |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                       |   |   |                                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>  |                              | 21e. INJURY OCCURRED   |  | 21f. HOW DID INJURY OCCUR?   |   |   |                                |
| 22. I hereby certify that I attended the deceased from <u>JAN 1, 1956</u> , to <u>OCT 11, 1956</u> , that I last saw the deceased alive on <u>10/11</u> , 19 <u>56</u> , and that death occurred at <u>1:50 PM</u> , from the causes and on the date stated above. |                              |  |  |  |   |   |                                |
| SIGNATURE<br><u>Robert A. Neely</u>  |                              | M.D.   |  | ADDRESS (Street, city, town, state)<br><u>301 MD. Arts Blvd. 1</u>                                 |   | DATE SIGNED<br><u>10/12/56</u>  |                                |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                              | DATE THEREOF<br><u>10-15-56</u>  |  | NAME OF CEMETERY OR CREMATORY<br><u>Catonville Cem.</u>  |   | LOCATION (City, town, or county) (State)<br><u>Balto.</u>                           |                                |
| 24. REC'D BY REGISTRAR<br>DATE <u>10-15-56</u>   |                              | REGISTRAR'S SIGNATURE  |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Lapley Funeral Home Catonsville, Md</u>                     |   |   |                                |

BUREAU A. B.

OCT 5 1956

RECEIVED

10085

## CERTIFICATE OF DEATH

Reg. Dist. No. 2

|  |                              |   |                                    |  |   |   |                  |
|--|------------------------------|---|------------------------------------|--|---|---|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Barto Co</u> MARYLAND  |                              |   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Barto Co</u> |   |   |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonville</u>  |                              | c. LENGTH OF STAY IN 1b   |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonville 28</u>                               |   |   |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>House of Pines</u>  |                              |   |                                    | d. STREET ADDRESS<br><u>2632 Frederick Rd</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| 3. NAME OF DECEASED (Type or print) <u>Miriam L Ogle</u><br>First Middle Last  |                              |   |                                    | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>11</u> Year <u>1956</u>   |   |   |                  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6/10/91</u> | 9. AGE (In years last birthday)<br><u>65</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. |   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Domestic housewife</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |                  |
| 13. FATHER'S NAME<br><u>Philip Moore</u>   |                              |   |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Ediga Grace</u>   |   |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)   |                              | 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT<br><u>M. Leo Ogle</u> Address  |   |   |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary artery disease (myocardial infarction)</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)              |                              |   |                                    |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 1/2 hrs.</u>   |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Insipidus</u>  |                              |   |                                    |  |   |   |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              |   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>19</u> p. m.  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |                  |
| 21. I certify that I attended the deceased from <u>12-31, 1955</u> to <u>1-11, 1956</u> , that I last saw the deceased alive on <u>1-11, 1956</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Catonville, Md.</u> DATE SIGNED <u>1-11-56</u> |                              |   |                                    |  |   |   |                  |
| ACTUAL SIGNATURE <u>S. Lloyd Johnson</u> M.D.  |                              |   |                                    | PHYSICIAN'S NAME (Type) <u>S. LLOYD JOHNSON, M.D.</u>  |   |   |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                              | 22b. DATE THEREOF   |                                    | 22c. NAME OF CEMETERY OR CREMATORY   |   | 22d. LOCATION (City, town, or county) (State)   |                  |
| <u>Burial</u>  |                              | <u>10/15/56</u>   |                                    | <u>Good Shepherd</u>   |   | <u>Howard Co Md</u>   |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>MacDonald</u> ADDRESS <u>Caton, 28</u>  |                              |   |                                    | 24a. REC'D BY REGISTRAR<br>DATE <u>10/15/56</u>  |   | 24b. REGISTRAR'S SIGNATURE  |                  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

100 100

RECEIVED

10086

CERTIFICATE OF DEATH

10068

Reg. Dist. No.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Baltimore, Md.</b> b. COUNTY                           |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |  |  |  | c. LENGTH OF STAY in 1b<br><b>18yrlmth2ldys</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>SPRING GROVE STATE HOSPITAL</b>  |  |  |  | d. STREET ADDRESS<br><b>2028 W. Lanvale Street</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>W. Ohlendorf</b> Last   |  |  |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>29</b> Year <b>19 56</b>  |  |  |  |
| 5. SEX<br><b>male</b>  |  | 6. COLOR OR RACE<br><b>white</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 23, 1870</b>  |  |
| 9. AGE (In years last birthday)<br><b>86</b> yrs.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>salesman</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |  |  | 13. FATHER'S NAME<br><b>unknown</b>   |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>   |  |  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>                                      |  |  |  |
| 16. SOCIAL SECURITY NO.<br><b>unknown</b>  |  |  |  | 17. INFORMANT<br>Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO (c) |  |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. n. p. m. <b>19</b>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                               |  |
| 20f. (City or town) (County) (State)   |  |  |  | 20g. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <b>July 1, 1953</b> , to <b>October 29, 1956</b> , that I last saw the deceased alive on <b>Oct. 29, 1956</b> , and that death occurred at <b>2:35 PM</b> , from the causes and on the date stated above.  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Stella Wachler</b> M.D.  |  |  |  | ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital</b> DATE SIGNED <b>10-29-56</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>   |  |  |  | Catonsville 28, Maryland  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 22b. DATE THEREOF<br><b>11-2-56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>MT. OLIVET CEM.</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore MD.</b>                                |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>G. Tuman Schuch</b>   |  |  |  | ADDRESS<br><b>3512 FREDERICK</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>1956</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>V. E. Hany</b>  |  |  |  |   |  |  |  |

BUREAU V. S.

RECEIVED



9977

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |  |  |   |   |
|---|----------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>DUNDALK 22</b><br>c. LENGTH OF STAY IN 1b<br><b>22</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>SAME</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>as #1</b> |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>7990 ST. MONICA DRIVE</b>  |                                  | d. STREET ADDRESS  |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>MARGARET ELIZABETH ORNDUFF</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>OCT. 4 1956</b>   |  |   |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>AUG. 26, 1885</b> | 9. AGE (In years last birthday)<br><b>71</b> yrs  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>WYNDALE, VIRGINIA</b>                             |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                  | 13. FATHER'S NAME<br><b>TOBY STARK</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>JUNK.</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |  | 17. INFORMANT<br>Address<br><b>MRS. CHARLES SAWYER - SAME</b>                                     |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accidents</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic Disease</b><br>DUE TO <b>Senility</b><br>(c) <b>Fractured (ununioned) hips for 5 years</b> |                                  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 1/2 years</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)   |                                  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |   |
| 20f. (City or town)   |                                  | (County)   |  | (State)   |   |
| 21. I certify that I attended the deceased from <b>Aug. 28, 1956</b> to <b>10/3, 1956</b> that I last saw the deceased alive on <b>10/3, 1956</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.  |                                  |  |  |   |   |
| ACTUAL SIGNATURE<br><b>David Owens</b>  |                                  | M.D. <b>Spawns</b>   |  | DATE SIGNED<br><b>10/7/56</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>David Owens</b>   |                                  |  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>10-7-56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>KREGER KNOLL</b>   |   |
| 22d. LOCATION (City, town, or county)   |                                  | (State)<br><b>ABINGDON, VIRGINIA</b>   |  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Walter D. Bradley, Dundalk, Md.</b>  |                                  | ADDRESS  |  | 24a. REC'D BY REGISTRAR<br><b>DATE</b>  |   |
| 24b. REGISTRAR'S SIGNATURE  |                                  |  |  |   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2711442

1 # 1.5

3 N 000000

OCT 8

10-5-20

10087

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

|   |                              |   |  |   |                           |   |            |
|---|------------------------------|---|--|---|---------------------------|---|------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND  |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admision)<br>a. STATE <u>MD</u> b. COUNTY |                           |   |            |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cub Hill</u>   |                              | c. LENGTH OF STAY IN 1b<br><u>33 years</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cub Hill</u>                 |                           |   |            |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>10037 Harford Rd.</u>  |                              |   |  | d. STREET ADDRESS<br><u>10037 Harford Rd</u>  |                           | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |            |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Charles</u> Middle <u>M</u> Last <u>Pearce</u>  |                              |   |  | 4. DATE OF DEATH<br>Month <u>OCT</u> Day <u>21</u> Year <u>1956</u>   |                           |   |            |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 28 1904</u> | 9. AGE (In years last birthday)<br><u>52</u> yrs.   | IF UNDER 1 YEAR<br>Months | IF UNDER 24 HRS.<br>Days  | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House Painter</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Painting</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |                           | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |            |
| 13. FATHER'S NAME<br><u>Charles Pearce</u>  |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Harman</u>  |                           |   |            |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>Yes</u><br>(If yes, give war or dates of service)  |                              | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><u>Edith Pearce</u> Address <u>10037 Harford Rd.</u>   |                           |   |            |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intoxication, alcoholic, acute</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alcoholism Chronic</u><br>DUE TO (c) <u>Cardiovascular, hypertension mild</u>  |                              |   |  |   |                           | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days</u>  |            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                              |   |  |   |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                        |                           |   |            |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |            |
| 21. I certify that I attended the deceased from <u>for about 19 years</u> , 19____, that I last saw the deceased alive on <u>Oct. 21</u> , 19 <u>56</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>5901 Ayleshire Road</u> DATE SIGNED<br>ACTUAL SIGNATURE <u>Joens N. Rudin</u> M.D.<br>PHYSICIAN'S NAME (Type) <u>LOUIS N. RUDIN</u> <u>Baltimore 12 Md</u> |                              |   |  |   |                           |   |            |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                              | 22b. DATE THEREOF<br><u>10-25-56</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Center Presby Terian Church</u>  |                           | 22d. LOCATION (City, town, or county) (State)<br><u>New Park PA</u>                               |            |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Chas F. Evans &amp; Son</u> ADDRESS <u>5802 Harford Rd.</u>  |                              |   |  | 24a. REC'D BY REGISTRAR<br><u>DATE: 25 1956</u>   |                           | 24b. REGISTRAR'S SIGNATURE<br><u>Will H. Evans</u>  |            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4

BUREAU V. S.

OCT 23 1956

RECEIVED

10088

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sparrows Point</b>  |   | c. LENGTH OF STAY IN 1b<br><b>11 years</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>616 E. St.</b>  |   | d. STREET ADDRESS<br><b>616 E. St.</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Dora</b> Middle <b>M.</b> Last <b>Peters</b>   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>19</b> Year <b>1956</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 12, 1870</b>  |
| 9. AGE (in years last birthday)<br><b>86 yrs.</b>  |   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Frederick Co. Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   |
| 13. FATHER'S NAME<br><b>Joseph Smith</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Little</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| 17. INFORMANT<br><b>Lillian Woodhead</b>   |   | Address<br><b>602 E. St. Sparrows Pt.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cerebrovascular disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>hypertension</b><br>DUE TO<br>(c) <b>Stroke</b>                          |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>26 yrs.</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>Sept 12, 1956</b> to <b>Oct 22, 1956</b> , that I last saw the deceased alive on <b>Sept 12, 1956</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>616 E. St. Baltimore, Md.</b> DATE SIGNED <b>Oct 22, 1956</b> |   |  |   |
| ACTUAL SIGNATURE <b>Dora Peters</b> M.D.   |   | PHYSICIAN'S NAME (Type) <b>Dora Peters</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>Oct. 22, 1956</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Lassahn Funeral Home</b>  |   | ADDRESS<br><b>7401 Belair Rd.</b>  | 24a. REC'D BY REGISTRAR<br><b>22 1956</b>   |
|  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Johnson &amp; Larkins</b>   |   |

MEDICAL CERTIFICATION

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file it with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
OCT 22 1956  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10089

CERTIFICATE OF DEATH

10072

Reg. Dist. No.

|   |                              |  |                                    |
|---|------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>        |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mt. Wilson</b>   |                              | c. LENGTH OF STAY IN 1b<br><b>25 days</b>  |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Mt. Wilson State Hospital</b>  |                              | d. STREET ADDRESS<br><b>4113 Hyden Court</b>   |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Agnes</b> Last <b>Pierce</b>   |                              | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>27</b> Year <b>1956</b>   |                                    |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/31/92</b> |
| 9. AGE (In years last birthday)<br><b>64</b> yrs.   |                              | IF UNDER 1 YEAR<br>Months Days Hours Min.  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Work</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY  |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                    |
| 13. FATHER'S NAME<br><b>John Appen</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>Mary Lawless</b>  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO<br><b>None</b>  |                                    |
| 17. INFORMANT<br><b>Hospital records, Mt. Wilson State Hospital</b>   |                              | Address  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br><b>351X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>TEX</b> (b) <b>Hypertension</b><br>DUE TO (c)   |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs.</b><br><b>Weeks</b>   |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Far Advanced Pulmonary Tuberculosis</b>   |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that I attended the deceased from <b>10/2</b> , 19 <b>56</b> , to <b>10/27</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10/27</b> , 19 <b>56</b> , and that death occurred at <b>7:40 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>William Newcomer, M.D.</b> <b>10/27/56</b> |                              |  |                                    |
| ACTUAL SIGNATURE<br><b>William Newcomer</b>   |                              | PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>   |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 22b. DATE THEREOF<br><b>10/31/56</b>   |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cem.</b>  |                              | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>   |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>McGully Funeral Home</b>   |                              | 24a. REC'D BY REGISTRAR<br><b>301956</b>   |                                    |
| ADDRESS<br><b>130 E. Fort Avenue</b>  |                              | 24b. REGISTRAR'S SIGNATURE<br><b>Kathryn Newcomer</b>  |                                    |

U. S. A.

1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10090 CERTIFICATE OF DEATH

10073 44

Reg. Dist. No.

|   |                                    |   |  |  |  |  |  |
|---|------------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                    |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>   |                                    |   |  | c. LENGTH OF STAY IN 1b <b>21 Days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>  |                                    |   |  | e. STREET ADDRESS <b>1 Park Lane</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>LEON (NMI) PINDER</b>   |                                    |   |  | 4. DATE OF DEATH Month Day Year<br><b>October 27 19 56</b>   |  |  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/6/10</b>  | 9. AGE (In years lost birthday) yrs.<br><b>46</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min   | IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                                    |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Cannery</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Cambridge, Maryland</b>          |  |  |
| 13. FATHER'S NAME<br><b>Caleb Pinder</b>  |                                    |   | 14. MOTHER'S MAIDEN NAME<br><b>Ella Pinder</b>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service<br><b>Yes WW-II</b>   |                                    |   | 16. SOCIAL SECURITY NO.<br><b>214 07 8956</b>  |  | 17. INFORMANT Address<br><b>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</b> |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF PANCREAS WITH METASTASIS,</b><br><b>157X DUE TO GENERALIZED</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b> |                                    |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. g. p. m. <b>19</b>  |                                    |   | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)           |  |  |
| 20f. (City or town)   |                                    |   | 20g. (County)  |  | 20h. (State)   |  |  |
| 21. I certify that I attended the deceased from <b>October 6, 1956</b> , to <b>October 27, 1956</b> , and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above.   |                                    |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Constantine J. Papastrat</b> M.D.   |                                    |   | ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Md.</b> DATE SIGNED <b>10/30/56</b>   |  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>CONSTANTINE J. PAPASTRAT, M.D.</b>   |                                    |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                    | 22b. DATE THEREOF<br><b>10-31-56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Chapel Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cambridge, Maryland</b>            |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles R. Law Mortuary, 802-04 Madison Ave. Balt.</b>   |                                    |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Harold L. Taylor</b>  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be detached for use as the burial-transit permit. The registrar will file the certificate with the burial, cremation, or removal, and in any event within 72 hours after death.

Picked up by St. Clair Undertaker, 111 Pine St. Cambridge, Md.

RECEIVED  
NOV 2 1956  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10091

## CERTIFICATE OF DEATH

## 10074 44

Reg. Dist. No.

|   |                                    |  |   |   |   |  |  |
|---|------------------------------------|--|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                    |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>  |                                    |  |   | c. LENGTH OF STAY IN 1b<br><b>4 Days</b>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Veterans Administration Hospital</b>   |                                    |  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                              |   |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>ERNEST G. POOLE</b>   |                                    |  |   | 4. DATE OF DEATH Month Day Year<br><b>October 8 1956</b>  |   |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 16, 1898</b> | 9. AGE (In years last birthday) yrs.<br><b>58</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Cement Work</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 13. FATHER'S NAME<br><b>Jerry Poole</b>   |                                    |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Lucinda Wood</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service)<br><b>WW I</b>   |                                    | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |   | 17. INFORMANT Address<br><b>Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Pulmonary emphysema 2. Arteriosclerosis, generalized</b> |                                    |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b>   |  |
|   |                                    |  |   |   |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>October 4, 1956</b> to <b>October 8, 1956</b> , and that death occurred at <b>3:50 A.M.</b> from the causes and on the date stated above.  |                                    |  |   |   |   |  |  |
| ACTUAL SIGNATURE <i>Irving Freeman</i> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>   |                                    |  |   | DATE SIGNED <b>10/8/56</b>  |   |  |  |
| PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D.</b>   |                                    |  |   |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                    | 22b. DATE THEREOF<br><b>10-10-56</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cemetery Baltimore, Maryland</b>                                |   | 22d. LOCATION (City, town, or county) (State)  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>802-04 Madison Ave.</b>  |                                    |  |   | 24a. REC'D BY REGISTRAR<br><b>Oct 25, 1956</b>  |   | 24b. REGISTRAR'S SIGNATURE <i>L. L. Harvey</i>   |  |

Charles R. Law Mortuary Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the funeral director's name and address on page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and return them to the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

327



CERTIFICATE OF DEATH

10075

Reg. Dist. No.

|  |  |  |   |
|--|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore County</u><br>2605 HICKRY AVE. MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>BALTIMORE</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  | e. STREET ADDRESS<br><u>2605 HICKRY AVE.</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>ANNA M. PRZYWARA</u>   |  | 4. DATE OF DEATH<br><u>OCT. 25 1956</u>  |   |
| 5 SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u>       | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>Feb. 24 1885</u>                           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSE WORK</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>AT HOME</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>OLAND</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>J. CALKA</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>UNK.</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  | 17. INFORMANT<br><u>John Przywara Son</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u><br>DUE TO (b) <u>Arterio-Sclerotic Cardiovascular Disease</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>5 yr</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. _____ 19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>7/1/50</u> to <u>10/25/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/25/56</u> , 19 <u>56</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.   |  |  |   |
| ACTUAL SIGNATURE <u>Joseph G. Laukaitis</u>  |  | DATE SIGNED <u>10/26/56</u>  |   |
| PHYSICIAN'S NAME (Type) <u>Joseph G. Laukaitis, M.D.</u>   |  | <u>679 Washington Blvd. Balto. 30, Md.</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 22b. DATE THEREOF<br><u>OCT. 29/56</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>HOLY ROSARY</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>BALTIMORE</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>F.R.D.W. OZANICKI</u>   |  | 24a. REC'D BY REGISTRAR<br><u>Oct 27 1956</u>  |   |
| ADDRESS<br><u>1930 EASTERN AVE.</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>R. W. DeLoach</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, Pages 1 and 2 should be filed with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

1917

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files or for your file to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10093 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10076  
Reg. Dist. No. 38

|  |                           |   |                                    |
|--|---------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>500 HICKORY LANE MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. STATE <u>MARYLAND</u> . c. COUNTY <u>BETHEL</u> <u>CONN.</u>    |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>TOWSON MD.   |                           | c. LENGTH OF STAY IN 1b   |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>500 HICKORY LANE   |                           | d. STREET ADDRESS<br>SUNSET HILL ROAD<br><del>500 HICKORY LANE</del>  |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>JOHN F. QUICK.   |                           | 4. DATE OF DEATH<br>Month Day Year<br>10 11 1956  |                                    |
| 5. SEX<br>MALE   | 6. COLOR OR RACE<br>WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Sept. 28, 1902 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>VICE PRESIDENT  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>MERCANTILE FOOD DIST. New York   |                                    |
| 11. BIRTHPLACE (State or foreign country)<br>New York  |                           | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                                    |
| 13. FATHER'S NAME<br>Nelson Quick  |                           | 14. MOTHER'S MAIDEN NAME<br>Mary Ann Holmes   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>None   |                           | 16. SOCIAL SECURITY NO.<br>None   |                                    |
| 17. INFORMANT<br>Family Information  |                           | Address   |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia - Aspiration of</u><br><u>921.0</u> DUE TO <u>BOLUS OF MEAT</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>322.0</u> DUE TO (b)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Acute Alcoholism</u> |                           |   |                                    |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Aspirated large hunk of meat</u>                         |                                    |
| 20c. TIME OF INJURY<br>Hour <u>9:36</u> p. m. Month <u>10/11</u> Year <u>1956</u>  |                           | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>HOME</u>   |                                    |
| 20e. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |                           | 20f. (City or town) (County) (State)<br><u>500 Hickory Lane Bethel MD</u>   |                                    |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .   |                           |   |                                    |
| ACTUAL SIGNATURE<br><u>R. S. FISHER</u>  |                           | M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                    |
| EXAMINER'S NAME (Type)<br>R. S. FISHER   |                           | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                    |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |                           | DATE SIGNED<br><u>10/12/56</u>  |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                           | 22b. DATE THEREOF<br><u>Oct. 15, 1956</u>   |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>St. Mary's Cemetery</u>   |                           | 22d. LOCATION (City, town, or county) (State)<br><u>Bethel, Conn.</u>   |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John Burns' Sons, Towson, Maryland</u><br><u>John C. Freeland, Danbury, Conn.</u>   |                           | 24a. REC'D BY REGISTRAR<br><u>DATE 10/12/56</u>   |                                    |
| 24b. REGISTRAR'S SIGNATURE<br><u>Mabel C. Gray</u>   |                           |   |                                    |

RECEIVED

1956

BUREAU A



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10094 CERTIFICATE OF DEATH

10077

Reg. Dist. No.

|  |                                 |   |  |
|--|---------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                                 | 2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)<br>o. STATE <u>Virginia</u> b. COUNTY <u>Roanoke</u>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Fort Howard</u>                     |                                 | c. LENGTH OF STAY IN lb<br><u>68 Days</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><u>Veterans Administration Hospital</u> |                                 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>STEVE D. RAGLAND</u>  |                                 | 4. DATE OF DEATH<br>Month Day Year<br><u>October 3 1956</u>   |  |
| 5 SEX<br><u>Male</u>   | 6 COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>July 3, 1915</u> |
| 9. AGE (In years last birthday) yrs.<br><u>41</u>  |                                 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Electrician</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Electrician</u>          |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Telephone Langley Field</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Oxford, Mississippi</u>  |                                 | 12 CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>  |  |
| 13. FATHER'S NAME<br><u>Sam Ragland</u>  |                                 | 14. MOTHER'S MAIDEN NAME<br><u>Mary E. Wooten</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>Yes</u>   |                                 | 16. SOCIAL SECURITY NO.<br><u>567-34-2605</u>   |  |
| 17. INFORMANT<br><u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard</u>   |                                 | Address<br><u>Maryland</u>  |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br><u>110X</u> DUE TO <u>MITRAL VALVULOTOMY</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____<br>DUE TO _____ |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>INSTANTANEOUS</u> |
|---|--|--|

|  |  |  |
|--|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Rheumatic Heart Disease, Mitral and Aortic Valves - Duration unknown</u> |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|--|--|--|

|  |   |  |                                      |
|--|---|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |                                      |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>VA 19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       | 20f. (City or town) (County) (State) |

21. I certify that I attended the deceased from July 27, 1956, to October 3, 1956, and that death occurred at 3:20 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND 10/4/56

NAME (Type) IRVING FREEMAN, M.D.

|   |                                     |  |  |
|---|-------------------------------------|--|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u> | 22b. DATE THEREOF<br><u>10-4-56</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Fairview Cemetery</u> | 22d. LOCATION (City, town, or county) (State)<br><u>Roanoke County, Virginia</u> |
|---|-------------------------------------|--|--|

|   |   |                            |
|---|---|----------------------------|
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Wm Cook-Blight, Inc.</u><br>ADDRESS<br><u>6009 Harford Rd., Balto. Md.</u> | 24a. REC'D BY REGISTRAR<br><u>DATE 10/18/56</u> | 24b. REGISTRAR'S SIGNATURE |
|---|---|----------------------------|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)  
15M 9/55

SHIPPED TO: John N. Oakley and Son, Church Ave., Roanoke, Va.

W. A. DUNN

CT 8 1 36

1936

10095

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Wm. Valentine Matthew Ratajczak</b>                                 |                                  |   | 2. DATE OF DEATH<br><b>Oct, 16, th, 1956</b>   |  |  |
| 3. PLACE OF DEATH<br><b>Baltimore City, Maryland 7213 Conley Street</b>                                       |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore 24</b> |  |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>At Home</b>   |                                  |   | 6. STREET ADDRESS (If rural, give location)<br><b>7213 Conley Street</b>   |  |  |
| c. Length of stay in Baltimore <b>76 yrs</b>  |                                  |   | 7. DATE OF BIRTH<br><b>Feb, 12-1879</b>  |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | 9. AGE (In years last birthday)<br><b>77</b>   |  | 10. Under 1 Year<br>Months: Days: <b>11</b>                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b> |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Poland</b>     |
| 13. FATHER'S NAME<br><b>Michael Ratajczak</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Antoinette Sobczak</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>                                |                                  |   | 16. SOCIAL SECURITY NO.<br><b>212-01-9401</b>  |  | 17. INFORMANT<br><b>Veronica Stachowiak 7213 Conley Street</b> |

|  |  |  |
|--|--|--|
| 18. <b>260X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Wernic poisoning - coma</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week?</b> |
| A. <b>arteriosclerotic CVD</b>   |  |  |
| B. <b>benign prostatic hypertrophy</b>   |  |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>diabetes mellitus</b>   |  | ?  |
| C. <b>diabetes mellitus</b>  |  |  |

|  |  |  |
|--|--|--|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |  |
|--|--|--|

|   |                        |  |   |
|---|------------------------|--|---|
| IF OPERATION WAS RELATED TO CAUSE OF DEATH. <b>ENTER NO.</b><br>PART I OR PART II | 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20. AUTOPSY?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |
|---|------------------------|--|---|

|   |   |                            |
|---|---|----------------------------|
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
|---|---|----------------------------|

|   |  |  |
|---|--|--|
| 22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>June 19 54</b> to <b>Oct 16 19 56</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>Oct 16 19 56</b> , and that death occurred at <b>12 Noon</b> , from the causes and on the date stated above. |  |  |
|---|--|--|

|  |   |                                     |
|--|---|-------------------------------------|
| 23A. SIGNATURE<br><b>Benton J. Lock MD</b> | 23B. ADDRESS<br><b>2936 E. Balto St</b> | 23C. DATE SIGNED<br><b>10/16/56</b> |
|--|---|-------------------------------------|

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>Oct, 20-1956</b> | 24C. NAME OF CEMETERY<br><b>St. Stanislaus Cemetery</b> | 24D. LOCATION (City, town, or county) (State)<br><b>1300 Dundalk Ave-Balto, Md.</b> |
|--|----------------------------------|---|---|

|  |   |  |
|--|---|--|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>OCT 17 1956</b> | REGISTRAR'S SIGNATURE<br><b>George R. Weber</b> | 25. FUNERAL DIRECTOR<br><b>George R. Weber 745 S. Ann St</b> |
|--|---|--|

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

BUREAU V. A.

OCT 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and page 1 and 2 should be filed with the registrar.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10096

## CERTIFICATE OF DEATH

10079 44

Reg. Dist. No.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>1</b>                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Box 323, Old North Point Rd.</b>   |   | d. STREET ADDRESS<br><b>Box 323, Old North Point Rd.</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Sebastian</b> <b>Rauh</b>   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>1</b> Year <b>1956</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 25, 1881</b>                                    |
| 9. AGE (In years last birthday) <b>75</b> yrs.  |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel Worker</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>George Rauh</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Augustina Boehner</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.<br><b>213-07-7185</b>   |   |
| 17. INFORMANT<br><b>George Rauh</b>   |   | Address<br><b>1915 Ellenwood Road</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA of Rectum C</b><br>DUE TO <b>Generalized Metastases</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO (b) _____<br>DUE TO (c) _____ |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>11 Mos.</b>                          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>Dec 30, 1955</b> to <b>Oct 1, 1956</b> , that I last saw the deceased alive on <b>Apr 30, 1956</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.   |   |   |   |
| ACTING SIGNATURE<br><b>M.B. Davis</b>   |   | ADDRESS (Street, city or town, state) <b>6800 MORRISON CON</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>M.B. DAVIS</b>  |   | DATE SIGNED<br><b>Dec 1956</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>Oct. 4, 1956</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Lilly &amp; Zeiler Inc., 403 S. Wolfe Street</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>1056</b>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>James I. Fisher</b>  |   |   |   |

RECEIVED

OCT 3 1956

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10097

CERTIFICATE OF DEATH

10080

Reg. Dist. No.

|  |  |   |  |  |  |   |   |
|--|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Balto.</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>                     |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Pikesville</u>  |  |   |  | c. LENGTH OF STAY IN 1b  |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>303 Reisterstown Rd.</u>  |  |   |  | d. STREET ADDRESS<br><u>303 Reisterstown Rd.</u>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>CHARLES</u> Middle <u>HARRY REISINGER</u> Last   |  |   |  | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>2</u> Year <u>19 56</u>   |  |   |   |
| 5. SEX<br><u>male</u>  |  | 6. COLOR OR RACE<br><u>white</u>              |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Dec. 3, 1885</u>                                 |   |
| 9. AGE (In years last birthday)<br><u>70</u> yrs   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.     |  | IF UNDER 24 HRS.   |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Rtd. Office Engineer</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Railroad</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Md.</u>                 |   |
| 13. FATHER'S NAME<br><u>Frederick P. Reisinger</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Julia Dietrich</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>  |  | 16. SOCIAL SECURITY NO.<br><u>705-10-5575</u> |  | 17. INFORMANT<br>Address<br><u>Mrs. G. Hartman Blamberg - 216 Chancery Rd.</u>   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br><u>4-20-1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO<br>(c) <u>Art. Sclerosis</u>  |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>34 hours</u><br><u>2 yrs</u><br><u>5 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> (b) <input type="checkbox"/> (c) <input type="checkbox"/> (d) <input type="checkbox"/> (e) <input type="checkbox"/> (f) <input type="checkbox"/> (g) <input type="checkbox"/> (h) <input type="checkbox"/> (i) <input type="checkbox"/> (j) <input type="checkbox"/> (k) <input type="checkbox"/> (l) <input type="checkbox"/> (m) <input type="checkbox"/> (n) <input type="checkbox"/> (o) <input type="checkbox"/> (p) <input type="checkbox"/> (q) <input type="checkbox"/> (r) <input type="checkbox"/> (s) <input type="checkbox"/> (t) <input type="checkbox"/> (u) <input type="checkbox"/> (v) <input type="checkbox"/> (w) <input type="checkbox"/> (x) <input type="checkbox"/> (y) <input type="checkbox"/> (z) <input type="checkbox"/> (aa) <input type="checkbox"/> (ab) <input type="checkbox"/> (ac) <input type="checkbox"/> (ad) <input type="checkbox"/> (ae) <input type="checkbox"/> (af) <input type="checkbox"/> (ag) <input type="checkbox"/> (ah) <input type="checkbox"/> (ai) <input type="checkbox"/> (aj) <input type="checkbox"/> (ak) <input type="checkbox"/> (al) <input type="checkbox"/> (am) <input type="checkbox"/> (an) <input type="checkbox"/> (ao) <input type="checkbox"/> (ap) <input type="checkbox"/> (aq) <input type="checkbox"/> (ar) <input type="checkbox"/> (as) <input type="checkbox"/> (at) <input type="checkbox"/> (au) <input type="checkbox"/> (av) <input type="checkbox"/> (aw) <input type="checkbox"/> (ax) <input type="checkbox"/> (ay) <input type="checkbox"/> (az) <input type="checkbox"/> (ba) <input type="checkbox"/> (bb) <input type="checkbox"/> (bc) <input type="checkbox"/> (bd) <input type="checkbox"/> (be) <input type="checkbox"/> (bf) <input type="checkbox"/> (bg) <input type="checkbox"/> (bh) <input type="checkbox"/> (bi) <input type="checkbox"/> (bj) <input type="checkbox"/> (bk) <input type="checkbox"/> (bl) <input type="checkbox"/> (bm) <input type="checkbox"/> (bn) <input type="checkbox"/> (bo) <input type="checkbox"/> (bp) <input type="checkbox"/> (bq) <input type="checkbox"/> (br) <input type="checkbox"/> (bs) <input type="checkbox"/> (bt) <input type="checkbox"/> (bu) <input type="checkbox"/> (bv) <input type="checkbox"/> (bw) <input type="checkbox"/> (bx) <input type="checkbox"/> (by) <input type="checkbox"/> (bz) <input type="checkbox"/> (ca) <input type="checkbox"/> (cb) <input type="checkbox"/> (cc) <input type="checkbox"/> (cd) <input type="checkbox"/> (ce) <input type="checkbox"/> (cf) <input type="checkbox"/> (cg) <input type="checkbox"/> (ch) <input type="checkbox"/> (ci) <input type="checkbox"/> (cj) <input type="checkbox"/> (ck) <input type="checkbox"/> (cl) <input type="checkbox"/> (cm) <input type="checkbox"/> (cn) <input type="checkbox"/> (co) <input type="checkbox"/> (cp) <input type="checkbox"/> (cq) <input type="checkbox"/> (cr) <input type="checkbox"/> (cs) <input type="checkbox"/> (ct) <input type="checkbox"/> (cu) <input type="checkbox"/> (cv) <input type="checkbox"/> (cw) <input type="checkbox"/> (cx) <input type="checkbox"/> (cy) <input type="checkbox"/> (cz) <input type="checkbox"/> (da) <input type="checkbox"/> (db) <input type="checkbox"/> (dc) <input type="checkbox"/> (dd) <input type="checkbox"/> (de) <input type="checkbox"/> (df) <input type="checkbox"/> (dg) <input type="checkbox"/> (dh) <input type="checkbox"/> (di) <input type="checkbox"/> (dj) <input type="checkbox"/> (dk) <input type="checkbox"/> (dl) <input type="checkbox"/> (dm) <input type="checkbox"/> (dn) <input type="checkbox"/> (do) <input type="checkbox"/> (dp) <input type="checkbox"/> (dq) <input type="checkbox"/> (dr) <input type="checkbox"/> (ds) <input type="checkbox"/> (dt) <input type="checkbox"/> (du) <input type="checkbox"/> (dv) <input type="checkbox"/> (dw) <input type="checkbox"/> (dx) <input type="checkbox"/> (dy) <input type="checkbox"/> (dz) <input type="checkbox"/> (ea) <input type="checkbox"/> (eb) <input type="checkbox"/> (ec) <input type="checkbox"/> (ed) <input type="checkbox"/> (ee) <input type="checkbox"/> (ef) <input type="checkbox"/> (eg) <input type="checkbox"/> (eh) <input type="checkbox"/> (ei) <input type="checkbox"/> (ej) <input type="checkbox"/> (ek) <input type="checkbox"/> (el) <input type="checkbox"/> (em) <input type="checkbox"/> (en) <input type="checkbox"/> (eo) <input type="checkbox"/> (ep) <input type="checkbox"/> (eq) <input type="checkbox"/> (er) <input type="checkbox"/> (es) <input type="checkbox"/> (et) <input type="checkbox"/> (eu) <input type="checkbox"/> (ev) <input type="checkbox"/> (ew) <input type="checkbox"/> (ex) <input type="checkbox"/> (ey) <input type="checkbox"/> (ez) <input type="checkbox"/> (fa) <input type="checkbox"/> (fb) <input type="checkbox"/> (fc) <input type="checkbox"/> (fd) <input type="checkbox"/> (fe) <input type="checkbox"/> (ff) <input type="checkbox"/> (fg) <input type="checkbox"/> (fh) <input type="checkbox"/> (fi) <input type="checkbox"/> (fj) <input type="checkbox"/> (fk) <input type="checkbox"/> (fl) <input type="checkbox"/> (fm) <input type="checkbox"/> (fn) <input type="checkbox"/> (fo) <input type="checkbox"/> (fp) <input type="checkbox"/> (fq) <input type="checkbox"/> (fr) <input type="checkbox"/> (fs) <input type="checkbox"/> (ft) <input type="checkbox"/> (fu) <input type="checkbox"/> (fv) <input type="checkbox"/> (fw) <input type="checkbox"/> (fx) <input type="checkbox"/> (fy) <input type="checkbox"/> (fz) <input type="checkbox"/> (ga) <input type="checkbox"/> (gb) <input type="checkbox"/> (gc) <input type="checkbox"/> (gd) <input type="checkbox"/> (ge) <input type="checkbox"/> (gf) <input type="checkbox"/> (gg) <input type="checkbox"/> (gh) <input type="checkbox"/> (gi) <input type="checkbox"/> (gj) <input type="checkbox"/> (gk) <input type="checkbox"/> (gl) <input type="checkbox"/> (gm) <input type="checkbox"/> (gn) <input type="checkbox"/> (go) <input type="checkbox"/> (gp) <input type="checkbox"/> (gq) <input type="checkbox"/> (gr) <input type="checkbox"/> (gs) <input type="checkbox"/> (gt) <input type="checkbox"/> (gu) <input type="checkbox"/> (gv) <input type="checkbox"/> (gw) <input type="checkbox"/> (gx) <input type="checkbox"/> (gy) <input type="checkbox"/> (gz) <input type="checkbox"/> (ha) <input type="checkbox"/> (hb) <input type="checkbox"/> (hc) <input type="checkbox"/> (hd) <input type="checkbox"/> (he) <input type="checkbox"/> (hf) <input type="checkbox"/> (hg) <input type="checkbox"/> (hh) <input type="checkbox"/> (hi) <input type="checkbox"/> (hj) <input type="checkbox"/> (hk) <input type="checkbox"/> (hl) <input type="checkbox"/> (hm) <input type="checkbox"/> (hn) <input type="checkbox"/> (ho) <input type="checkbox"/> (hp) <input type="checkbox"/> (hq) <input type="checkbox"/> (hr) <input type="checkbox"/> (hs) <input type="checkbox"/> (ht) <input type="checkbox"/> (hu) <input type="checkbox"/> (hv) <input type="checkbox"/> (hw) <input type="checkbox"/> (hx) <input type="checkbox"/> (hy) <input type="checkbox"/> (hz) <input type="checkbox"/> (ia) <input type="checkbox"/> (ib) <input type="checkbox"/> (ic) <input type="checkbox"/> (id) <input type="checkbox"/> (ie) <input type="checkbox"/> (if) <input type="checkbox"/> (ig) <input type="checkbox"/> (ih) <input type="checkbox"/> (ii) <input type="checkbox"/> (ij) <input type="checkbox"/> (ik) <input type="checkbox"/> (il) <input type="checkbox"/> (im) <input type="checkbox"/> (in) <input type="checkbox"/> (io) <input type="checkbox"/> (ip) <input type="checkbox"/> (iq) <input type="checkbox"/> (ir) <input type="checkbox"/> (is) <input type="checkbox"/> (it) <input type="checkbox"/> (iu) <input type="checkbox"/> (iv) <input type="checkbox"/> (iw) <input type="checkbox"/> (ix) <input type="checkbox"/> (iy) <input type="checkbox"/> (iz) <input type="checkbox"/> (ja) <input type="checkbox"/> (jb) <input type="checkbox"/> (jc) <input type="checkbox"/> (jd) <input type="checkbox"/> (je) <input type="checkbox"/> (jf) <input type="checkbox"/> (jg) <input type="checkbox"/> (jh) <input type="checkbox"/> (ji) <input type="checkbox"/> (jj) <input type="checkbox"/> (jk) <input type="checkbox"/> (jl) <input type="checkbox"/> (jm) <input type="checkbox"/> (jn) <input type="checkbox"/> (jo) <input type="checkbox"/> (jp) <input type="checkbox"/> (jq) <input type="checkbox"/> (jr) <input type="checkbox"/> (js) <input type="checkbox"/> (jt) <input type="checkbox"/> (ju) <input type="checkbox"/> (jv) <input type="checkbox"/> (jw) <input type="checkbox"/> (jx) <input type="checkbox"/> (jy) <input type="checkbox"/> (jz) <input type="checkbox"/> (ka) <input type="checkbox"/> (kb) <input type="checkbox"/> (kc) <input type="checkbox"/> (kd) <input type="checkbox"/> (ke) <input type="checkbox"/> (kf) <input type="checkbox"/> (kg) <input type="checkbox"/> (kh) <input type="checkbox"/> (ki) <input type="checkbox"/> (kj) <input type="checkbox"/> (kl) <input type="checkbox"/> (km) <input type="checkbox"/> (kn) <input type="checkbox"/> (ko) <input type="checkbox"/> (kp) <input type="checkbox"/> (kq) <input type="checkbox"/> (kr) <input type="checkbox"/> (ks) <input type="checkbox"/> (kt) <input type="checkbox"/> (ku) <input type="checkbox"/> (kv) <input type="checkbox"/> (kw) <input type="checkbox"/> (kx) <input type="checkbox"/> (ky) <input type="checkbox"/> (kz) <input type="checkbox"/> (la) <input type="checkbox"/> (lb) <input type="checkbox"/> (lc) <input type="checkbox"/> (ld) <input type="checkbox"/> (le) <input type="checkbox"/> (lf) <input type="checkbox"/> (lg) <input type="checkbox"/> (lh) <input type="checkbox"/> (li) <input type="checkbox"/> (lj) <input type="checkbox"/> (lk) <input type="checkbox"/> (ll) <input type="checkbox"/> (lm) <input type="checkbox"/> (ln) <input type="checkbox"/> (lo) <input type="checkbox"/> (lp) <input type="checkbox"/> (lq) <input type="checkbox"/> (lr) <input type="checkbox"/> (ls) <input type="checkbox"/> (lt) <input type="checkbox"/> (lu) <input type="checkbox"/> (lv) <input type="checkbox"/> (lw) <input type="checkbox"/> (lx) <input type="checkbox"/> (ly) <input type="checkbox"/> (lz) <input type="checkbox"/> (ma) <input type="checkbox"/> (mb) <input type="checkbox"/> (mc) <input type="checkbox"/> (md) <input type="checkbox"/> (me) <input type="checkbox"/> (mf) <input type="checkbox"/> (mg) <input type="checkbox"/> (mh) <input type="checkbox"/> (mi) <input type="checkbox"/> (mj) <input type="checkbox"/> (mk) <input type="checkbox"/> (ml) <input type="checkbox"/> (mm) <input type="checkbox"/> (mn) <input type="checkbox"/> (mo) <input type="checkbox"/> (mp) <input type="checkbox"/> (mq) <input type="checkbox"/> (mr) <input type="checkbox"/> (ms) <input type="checkbox"/> (mt) <input type="checkbox"/> (mu) <input type="checkbox"/> (mv) <input type="checkbox"/> (mw) <input type="checkbox"/> (mx) <input type="checkbox"/> (my) <input type="checkbox"/> (mz) <input type="checkbox"/> (na) <input type="checkbox"/> (nb) <input type="checkbox"/> (nc) <input type="checkbox"/> (nd) <input type="checkbox"/> (ne) <input type="checkbox"/> (nf) <input type="checkbox"/> (ng) <input type="checkbox"/> (nh) <input type="checkbox"/> (ni) <input type="checkbox"/> (nj) <input type="checkbox"/> (nk) <input type="checkbox"/> (nl) <input type="checkbox"/> (nm) <input type="checkbox"/> (nn) <input type="checkbox"/> (no) <input type="checkbox"/> (np) <input type="checkbox"/> (nq) <input type="checkbox"/> (nr) <input type="checkbox"/> (ns) <input type="checkbox"/> (nt) <input type="checkbox"/> (nu) <input type="checkbox"/> (nv) <input type="checkbox"/> (nw) <input type="checkbox"/> (nx) <input type="checkbox"/> (ny) <input type="checkbox"/> (nz) <input type="checkbox"/> (oa) <input type="checkbox"/> (ob) <input type="checkbox"/> (oc) <input type="checkbox"/> (od) <input type="checkbox"/> (oe) <input type="checkbox"/> (of) <input type="checkbox"/> (og) <input type="checkbox"/> (oh) <input type="checkbox"/> (oi) <input type="checkbox"/> (oj) <input type="checkbox"/> (ok) <input type="checkbox"/> (ol) <input type="checkbox"/> (om) <input type="checkbox"/> (on) <input type="checkbox"/> (oo) <input type="checkbox"/> (op) <input type="checkbox"/> (oq) <input type="checkbox"/> (or) <input type="checkbox"/> (os) <input type="checkbox"/> (ot) <input type="checkbox"/> (ou) <input type="checkbox"/> (ov) <input type="checkbox"/> (ow) <input type="checkbox"/> (ox) <input type="checkbox"/> (oy) <input type="checkbox"/> (oz) <input type="checkbox"/> (pa) <input type="checkbox"/> (pb) <input type="checkbox"/> (pc) <input type="checkbox"/> (pd) <input type="checkbox"/> (pe) <input type="checkbox"/> (pf) <input type="checkbox"/> (pg) <input type="checkbox"/> (ph) <input type="checkbox"/> (pi) <input type="checkbox"/> (pj) <input type="checkbox"/> (pk) <input type="checkbox"/> (pl) <input type="checkbox"/> (pm) <input type="checkbox"/> (pn) <input type="checkbox"/> (po) <input type="checkbox"/> (pp) <input type="checkbox"/> (pq) <input type="checkbox"/> (pr) <input type="checkbox"/> (ps) <input type="checkbox"/> (pt) <input type="checkbox"/> (pu) <input type="checkbox"/> (pv) <input type="checkbox"/> (pw) <input type="checkbox"/> (px) <input type="checkbox"/> (py) <input type="checkbox"/> (pz) <input type="checkbox"/> (qa) <input type="checkbox"/> (qb) <input type="checkbox"/> (qc) <input type="checkbox"/> (qd) <input type="checkbox"/> (qe) <input type="checkbox"/> (qf) <input type="checkbox"/> (qg) <input type="checkbox"/> (qh) <input type="checkbox"/> (qi) <input type="checkbox"/> (qj) <input type="checkbox"/> (qk) <input type="checkbox"/> (ql) <input type="checkbox"/> (qm) <input type="checkbox"/> (qn) <input type="checkbox"/> (qo) <input type="checkbox"/> (qp) <input type="checkbox"/> (qq) <input type="checkbox"/> (qr) <input type="checkbox"/> (qs) <input type="checkbox"/> (qt) <input type="checkbox"/> (qu) <input type="checkbox"/> (qv) <input type="checkbox"/> (qw) <input type="checkbox"/> (qx) <input type="checkbox"/> (qy) <input type="checkbox"/> (qz) <input type="checkbox"/> (ra) <input type="checkbox"/> (rb) <input type="checkbox"/> (rc) <input type="checkbox"/> (rd) <input type="checkbox"/> (re) <input type="checkbox"/> (rf) <input type="checkbox"/> (rg) <input type="checkbox"/> (rh) <input type="checkbox"/> (ri) <input type="checkbox"/> (rj) <input type="checkbox"/> (rk) <input type="checkbox"/> (rl) <input type="checkbox"/> (rm) <input type="checkbox"/> (rn) <input type="checkbox"/> (ro) <input type="checkbox"/> (rp) <input type="checkbox"/> (rq) <input type="checkbox"/> (rr) <input type="checkbox"/> (rs) <input type="checkbox"/> (rt) <input type="checkbox"/> (ru) <input type="checkbox"/> (rv) <input type="checkbox"/> (rw) <input type="checkbox"/> (rx) <input type="checkbox"/> (ry) <input type="checkbox"/> (rz) <input type="checkbox"/> (sa) <input type="checkbox"/> (sb) <input type="checkbox"/> (sc) <input type="checkbox"/> (sd) <input type="checkbox"/> (se) <input type="checkbox"/> (sf) <input type="checkbox"/> (sg) <input type="checkbox"/> (sh) <input type="checkbox"/> (si) <input type="checkbox"/> (sj) <input type="checkbox"/> (sk) <input type="checkbox"/> (sl) <input type="checkbox"/> (sm) <input type="checkbox"/> (sn) <input type="checkbox"/> (so) <input type="checkbox"/> (sp) <input type="checkbox"/> (sq) <input type="checkbox"/> (sr) <input type="checkbox"/> (ss) <input type="checkbox"/> (st) <input type="checkbox"/> (su) <input type="checkbox"/> (sv) <input type="checkbox"/> (sw) <input type="checkbox"/> (sx) <input type="checkbox"/> (sy) <input type="checkbox"/> (sz) <input type="checkbox"/> (ta) <input type="checkbox"/> (tb) <input type="checkbox"/> (tc) <input type="checkbox"/> (td) <input type="checkbox"/> (te) <input type="checkbox"/> (tf) <input type="checkbox"/> (tg) <input type="checkbox"/> (th) <input type="checkbox"/> (ti) <input type="checkbox"/> (tj) <input type="checkbox"/> (tk) <input type="checkbox"/> (tl) <input type="checkbox"/> (tm) <input type="checkbox"/> (tn) <input type="checkbox"/> (to) <input type="checkbox"/> (tp) <input type="checkbox"/> (tq) <input type="checkbox"/> (tr) <input type="checkbox"/> (ts) <input type="checkbox"/> (tt) <input type="checkbox"/> (tu) <input type="checkbox"/> (tv) <input type="checkbox"/> (tw) <input type="checkbox"/> (tx) <input type="checkbox"/> (ty) <input type="checkbox"/> (tz) <input type="checkbox"/> (ua) <input type="checkbox"/> (ub) <input type="checkbox"/> (uc) <input type="checkbox"/> (ud) <input type="checkbox"/> (ue) <input type="checkbox"/> (uf) <input type="checkbox"/> (ug) <input type="checkbox"/> (uh) <input type="checkbox"/> (ui) <input type="checkbox"/> (uj) <input type="checkbox"/> (uk) <input type="checkbox"/> (ul) <input type="checkbox"/> (um) <input type="checkbox"/> (un) <input type="checkbox"/> (uo) <input type="checkbox"/> (up) <input type="checkbox"/> (uq) <input type="checkbox"/> (ur) <input type="checkbox"/> (us) <input type="checkbox"/> (ut) <input type="checkbox"/> (uu) <input type="checkbox"/> (uv) <input type="checkbox"/> (uw) <input type="checkbox"/> (ux) <input type="checkbox"/> (uy) <input type="checkbox"/> (uz) <input type="checkbox"/> (va) <input type="checkbox"/> (vb) <input type="checkbox"/> (vc) <input type="checkbox"/> (vd) <input type="checkbox"/> (ve) <input type="checkbox"/> (vf) <input type="checkbox"/> (vg) <input type="checkbox"/> (vh) <input type="checkbox"/> (vi) <input type="checkbox"/> (vj) <input type="checkbox"/> (vk) <input type="checkbox"/> (vl) <input type="checkbox"/> (vm) <input type="checkbox"/> (vn) <input type="checkbox"/> (vo) <input type="checkbox"/> (vp) <input type="checkbox"/> (vq) <input type="checkbox"/> (vr) <input type="checkbox"/> (vs) <input type="checkbox"/> (vt) <input type="checkbox"/> (vu) <input type="checkbox"/> (vv) <input type="checkbox"/> (vw) <input type="checkbox"/> (vx) <input type="checkbox"/> (vy) <input type="checkbox"/> (vz) <input type="checkbox"/> (wa) <input type="checkbox"/> (wb) <input type="checkbox"/> (wc) <input type="checkbox"/> (wd) <input type="checkbox"/> (we) <input type="checkbox"/> (wf) <input type="checkbox"/> (wg) <input type="checkbox"/> (wh) <input type="checkbox"/> (wi) <input type="checkbox"/> (wj) <input type="checkbox"/> (wk) <input type="checkbox"/> (wl) <input type="checkbox"/> (wm) <input type="checkbox"/> (wn) <input type="checkbox"/> (wo) <input type="checkbox"/> (wp) <input type="checkbox"/> (wq) <input type="checkbox"/> (wr) <input type="checkbox"/> (ws) <input type="checkbox"/> (wt) <input type="checkbox"/> (wu) <input type="checkbox"/> (wv) <input type="checkbox"/> (ww) <input type="checkbox"/> (wx) <input type="checkbox"/> (wy) <input type="checkbox"/> (wz) <input type="checkbox"/> (xa) <input type="checkbox"/> (xb) <input type="checkbox"/> (xc) <input type="checkbox"/> (xd) <input type="checkbox"/> (xe) <input type="checkbox"/> (xf) <input type="checkbox"/> (xg) <input type="checkbox"/> (xh) <input type="checkbox"/> (xi) <input type="checkbox"/> (xj) <input type="checkbox"/> (xk) <input type="checkbox"/> (xl) <input type="checkbox"/> (xm) <input type="checkbox"/> (xn) <input type="checkbox"/> (xo) <input type="checkbox"/> (xp) <input type="checkbox"/> (xq) <input type="checkbox"/> (xr) <input type="checkbox"/> (xs) <input type="checkbox"/> (xt) <input type="checkbox"/> (xu) <input type="checkbox"/> (xv) <input type="checkbox"/> (xw) <input type="checkbox"/> (xx) <input type="checkbox"/> (xy) <input type="checkbox"/> (xz) <input type="checkbox"/> (ya) <input type="checkbox"/> (yb) <input type="checkbox"/> (yc) <input type="checkbox"/> (yd) <input type="checkbox"/> (ye) <input type="checkbox"/> (yf) <input type="checkbox"/> (yg) <input type="checkbox"/> (yh) <input type="checkbox"/> (yi) <input type="checkbox"/> (yj) <input type="checkbox"/> (yk) <input type="checkbox"/> (yl) <input type="checkbox"/> (ym) <input type="checkbox"/> (yn) <input type="checkbox"/> (yo) <input type="checkbox"/> (yp) <input type="checkbox"/> (yq) <input type="checkbox"/> (yr) <input type="checkbox"/> (ys) <input type="checkbox"/> (yt) <input type="checkbox"/> (yu) <input type="checkbox"/> (yv) <input type="checkbox"/> (yw) <input type="checkbox"/> (yx) <input type="checkbox"/> (yy) <input type="checkbox"/> (yz) <input type="checkbox"/> (za) <input type="checkbox"/> (zb) <input type="checkbox"/> (zc) <input type="checkbox"/> (zd) <input type="checkbox"/> (ze) <input type="checkbox"/> (zf) <input type="checkbox"/> (zg) <input type="checkbox"/> (zh) <input type="checkbox"/> (zi) <input type="checkbox"/> (zj) <input type="checkbox"/> (zk) <input type="checkbox"/> (zl) <input type="checkbox"/> (zm) <input type="checkbox"/> (zn) <input type="checkbox"/> (zo) <input type="checkbox"/> (zp) <input type="checkbox"/> (zq) <input type="checkbox"/> (zr) <input type="checkbox"/> (zs) <input type="checkbox"/> (zt) <input type="checkbox"/> (zu) <input type="checkbox"/> (zv) <input type="checkbox"/> (zw) <input type="checkbox"/> (zx) <input type="checkbox"/> (zy) <input type="checkbox"/> (zz) |  |   |  |  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   |
| 20f. (City or town)  |  |   |  | 20g. (County)  |  | 20h. (State)  |   |
| 21. I certify that I attended the deceased from <u>JAN.</u> , 19 <u>54</u> , to <u>Oct 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 2</u> , 19 <u>56</u> , and that death occurred at <u>2:30</u> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>1331 Reisterstown Rd Pikesville, Md</u><br>DATE SIGNED <u>10/3/56</u><br>ACTUAL SIGNATURE <u>James H. Miller M.D.</u><br>PHYSICIAN'S NAME (Type) <u>Dr. James H. Miller</u>   |  |   |  |  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>9/5/56</u>            |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Druid Ridge Cem.</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Pikesville, Md.</u> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Wm. J. Lickner &amp; Sons - Balto. 17, Md</u>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>Oct 5 1956</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Wm. J. Lickner</u>                     |   |

BUREAU V. S.

OCT 4 1956

विश्व अंतरिक्ष



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10098

## CERTIFICATE OF DEATH

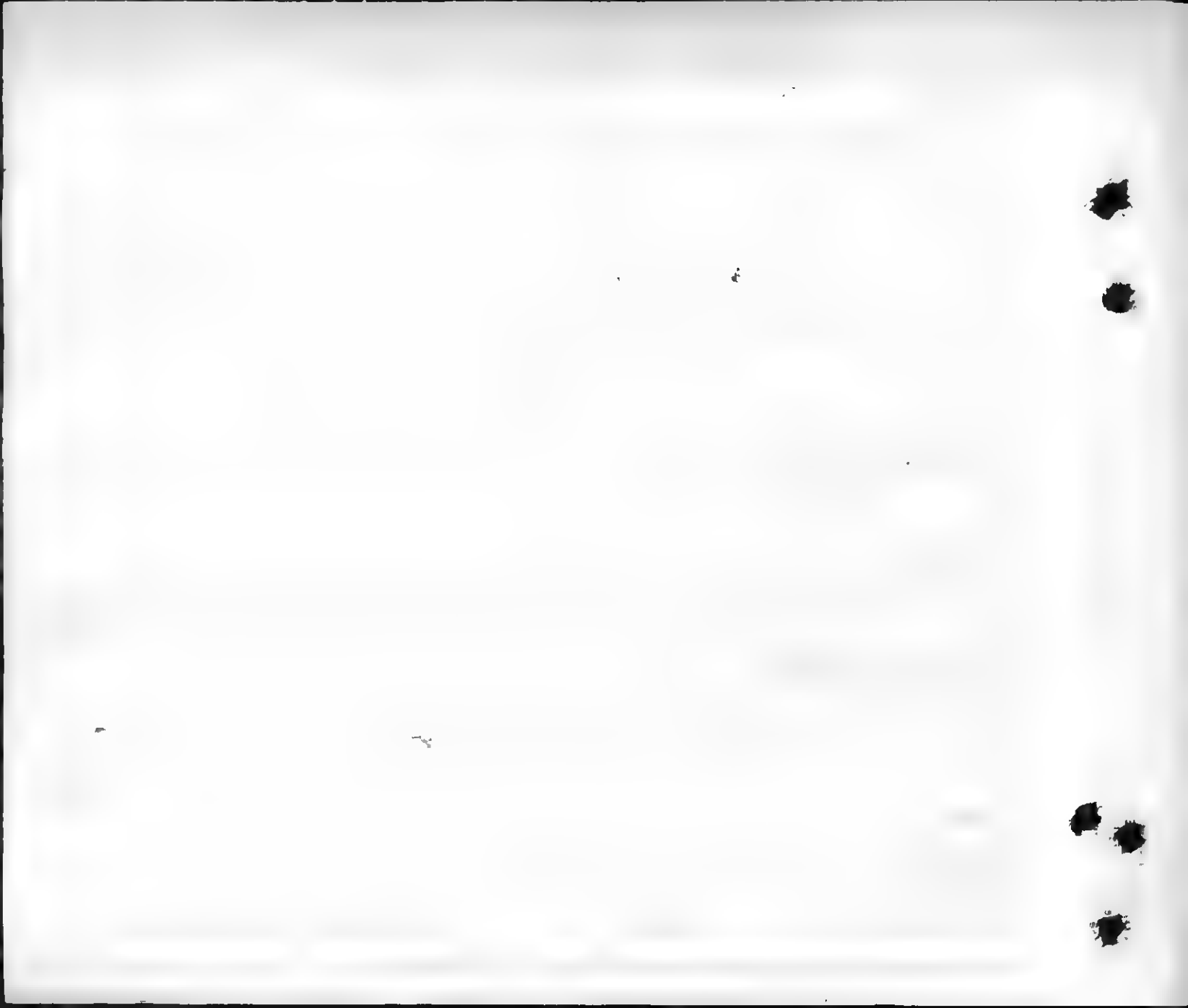
10081

Reg. Dist. No

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE OF DEATH   |  |
| Phillip P. Rice.  |  | October 2, 1956  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE<br>Maryland  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br>Catonsville<br>Shady Nook Nursing Home.  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore  |  |
| c. Length of stay in Baltimore<br>Life  |  | D. STREET ADDRESS (If rural, give location)<br>4003 Hickory Ave  |  |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White                            | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Widower.  | 8. DATE OF BIRTH<br>October 8/1909                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Traffic  | 10B. KIND OF BUSINESS OR INDUSTRY<br>McCormick & Co. | 9. AGE (in years last birthday)<br>46  | 11. BIRTHPLACE (State or foreign country)<br>Maryland. |
| 13. FATHER'S NAME<br>William Rice.  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>(If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO<br>213 10 8187  | 14. MOTHER'S MAIDEN NAME<br>Lilly M. Wilder.           |
| 17. INFORMANT<br>Mrs. Vivian Caga   |  | ADDRESS<br>4003 Hickory Ave.   |  |
| 18. CAUSE OF DEATH  |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DUE TO<br>Broncho Pneumonia |  | INTERVAL BETWEEN ONSET AND DEATH<br>3 Days.  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>Carcinomatosis  |  | 4 years  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>DUE TO<br>Primary brain metastasis  |  | 4 years  |  |
| 19. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |
| 17. DATE OF OPERATION   |  | 20. AUTOPSY?   |  |
| 18. DATE OF OPERATION   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 19. DATE OF OPERATION   |  | 21. HOW DID INJURY OCCUR?  |  |
| 20. DATE OF OPERATION   |  | 22. I certify that (I) (this hospital) attended the deceased from August 1956 to October 2, 1956, that (I) (we) last saw the deceased alive on Oct 1, 1956, and that death occurred at 11:00 A.M., from the causes and on the date stated above. |  |
| 23A. SIGNATURE<br>W. Schamberger  |  | 23B. ADDRESS<br>1118 St. Paul St.  |  |
| 23C. DATE SIGNED<br>10/3/56   |  | 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |
| 24B. DATE<br>Oct 5, 1956  |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park.   |  |
| 24D. LOCATION (City, town, or county)<br>Windsor Mill Rd, Md.   |  | 25. FUNERAL DIRECTOR<br>Austin E. Donovan  |  |
| 25. FUNERAL DIRECTOR<br>Austin E. Donovan   |  | 3818 Roland  |  |

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER.



## .10099 CERTIFICATE OF DEATH

Reg. Dist. No.

44

|   |                                  |  |                                   |  |  |   |  |
|---|----------------------------------|--|-----------------------------------|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                                  |  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admittance)<br>a. STATE <u>Maryland</u> b. COUNTY |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Fort Howard</u>  |                                  |  |                                   | c. LENGTH OF STAY IN TB<br><u>50 days</u>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Veterans Administration Hospital</u>   |                                  |  |                                   | d. STREET ADDRESS<br><u>4106 Edmondson Avenue</u>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>FRED</u> Middle <u>(NMI)</u> Last <u>ROWAN</u>  |                                  |  |                                   | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>6</u> Year <u>1956</u>   |  |   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><u>7/9/88</u> | 9. AGE (In years last birthday)<br><u>68</u> yrs   | IF UNDER 1 YEAR<br>Months <u>68</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | IF UNDER 24 HRS<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Storeroom Keeper</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Electric Co.</u>   |                                   | 11. BIRTHPLACE (State or foreign country)<br><u>Iowa</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                 |  |
| 13. FATHER'S NAME<br><u>John W. Rowan</u>   |                                  |  |                                   | 14. MOTHER'S MAIDEN NAME<br><u>Mary McNamara</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>Yes</u> <u>WWI</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>361-03-9236</u>  |                                   | 17. INFORMANT<br><u>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA PANCREAS WITH MEDIASTINAL, HEPATIC</u><br>DUE TO <u>BONE METASTASIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>SUPERIOR VENA CAVA OBSTRUCTION</u> |                                  |  |                                   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>UNKNOWN</u>                            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>0</u> p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>August 17</u> , 19 <u>56</u> , to <u>October 6</u> , 19 <u>56</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>M.D. Veterans Administration Hospital</u> DATE SIGNED <u>10/6/56</u>   |                                  |  |                                   |  |  |   |  |
| ACTUAL SIGNATURE <u>[Signature]</u>   |                                  | PHYSICIAN'S NAME (Type) <u>PIJANOWSKI, M. D.</u> <u>FORT HOWARD, Md.</u>   |                                   |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>10-10-56</u>   |                                   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore National</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Cook-Flight, Inc.</u><br><u>5009 Harford Rd., Balto., Md.</u>  |                                  |  |                                   | 24a. REC'D BY REGISTRAR<br><u>DATE 10/10/56</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Dawson L. Garkner</u>                        |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's office, it should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 10 1956

U.S. DEPT. OF JUSTICE

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10100

## CERTIFICATE OF DEATH

10083

Reg. Dist. No.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>16 Fusting Ave.</u> <u>MARYLAND</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY                                   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nursing Home</u>  |  |   |  | d. STREET ADDRESS <u>6107 Regent Park Road</u>   |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Marion Vincent Russell</u>  |  |   |  | 4. DATE OF DEATH Month Day Year<br><u>Oct. 25 19 56</u>  |  |  |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>April 26, 1874</u>                              |  |
| 9. AGE (In years last birthday) yrs. <u>82</u>  |  | IF UNDER 1 YEAR Months Days Hours Min     |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Hotel Mgr.</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore</u>          |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S. A.</u>  |  |   |  |  |  |  |  |
| 13. FATHER'S NAME<br><u>William Russell</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Roseanna Patterson</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.  |  |  |  |
| 17. INFORMANT<br><u>William T. Russell</u>  |  |   |  | Address<br><u>6107 Regent Park Road, Balto. Md.</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio-vascular renal disease</u><br><u>442X</u> DUE TO (b) <u>Acute Uremia</u><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)   |  |   |  | (County)   |  | (State)  |  |
| 21. I certify that I attended the deceased from <u>Jan. 11, 1952</u> to <u>October 25, 1956</u> , that I last saw the deceased alive on <u>October 25, 1956</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>4116 Edmondson Avenue</u> DATE SIGNED <u>10/26/56</u>   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>George A. Knipp</u>   |  |   |  | M.D. <u>George A. Knipp, M. D.</u>   |  |  |  |
| PHYSICIAN'S NAME (Type)   |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>Oct. 27, 1956</u> |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>New Cathedral Cem.</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Henry W. Jenkins &amp; Sons Co., Inc.</u>  |  |   |  | ADDRESS<br><u>4905 York Road Balto. 12, Md.</u>  |  | 24a. REC'D BY REGISTRAR<br><u>Oct. 30, 1956</u>                        |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>P. E. Harry</u>  |  |   |  |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. The registrar will remove the burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 30 1901

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10101

CERTIFICATE OF DEATH

1008448  
 Reg. Dist. No.

|   |                           |   |                                       |
|---|---------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>   |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Overlea</b>  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Overlea</b>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>209 Leslie Ave.</b>  |                           | d. STREET ADDRESS<br><b>209 Leslie Ave.</b>   |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HERMAN</b> Middle <b>Rudolf</b> Last <b>Schmidt</b>   |                           | 4. DATE OF DEATH<br>Month <b>Oct</b> Day <b>29</b> Year <b>1956</b>   |                                       |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9 May 1887</b> |
| 9. AGE (In years last birthday) <b>69</b> yrs.  |                           | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cobbler</b>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Shoe Repair</b>   |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>Germany</b>   |                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                       |
| 13. FATHER'S NAME<br><b>Herman B. Schmidt</b>   |                           | 14. MOTHER'S MAIDEN NAME<br><b>Unknown Unknown</b>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                           | 16. SOCIAL SECURITY NO<br><b>218-14-9866</b>  |                                       |
| 17. INFORMANT<br><b>Mrs. Pauline H. Schmidt</b>   |                           | Address<br><b>209 Leslie Ave.</b>   |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br><b>4.10.1</b> DUE TO <b>Uncontrolled fibrillation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Drugs used for hypertension</b><br>(c) <b>2 hr</b> |                           | INTERVAL BETWEEN ONSET AND DEATH<br><b>30 min</b>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <b>Hypertension</b>  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that I attended the deceased from <b>10:30 AM 10-29-56</b> , to <b>11:30 AM 10-29-56</b> , that I last saw the deceased alive on <b>11:30 AM 10-29-56</b> , and that death occurred at <b>11:55 PM</b> , from the causes and on the date stated above.  |                           |   |                                       |
| ACTUAL SIGNATURE <b>John C. Hyatt, M.D.</b>   |                           | ADDRESS (Street, city or town, state) DATE SIGNED <b>7:57 PM 10-29-56</b>   |                                       |
| PHYSICIAN'S NAME (Type) <b>JOHN C. HYATT, M.D.</b>  |                           |   |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                           | 22b. DATE THEREOF<br><b>Nov. 2, 1956</b>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |                           | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Cassidy Funeral Home</b>   |                           | 24a. REC'D BY REGISTRAR<br><b>DATE 11-1-1956</b>  |                                       |
| ADDRESS<br><b>7401 Belair Rd.</b>   |                           | 24b. REGISTRAR'S SIGNATURE<br><b>Mrs. H. L. L. L.</b>   |                                       |

BUREAU V. S.

NOV 1 1930

RECEIVED



**10102**

**CERTIFICATE OF DEATH**

Reg. Dist. No.

|   |                                  |  |   |   |  |   |   |
|---|----------------------------------|--|---|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Balto.</b> <b>MARYLAND</b>  |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |                                  |  |   | c. LENGTH OF STAY IN 1b   |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Towson Convalescent Home-301 Chesapeake Ave.</b>   |                                  |  |   | e. STREET ADDRESS<br><b>108 Wyndhurst Ave.</b>  |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARY</b> Middle <b>AMELIA</b> Last <b>SCOTT</b>   |                                  |  |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>3,</b> Year <b>19 56</b>   |  |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 7, 1880</b>   | 9. AGE (In years last birthday)<br><b>75</b> yrs  | IF UNDER 1 YEAR<br>Months Days Hours Min.                              | IF UNDER 24 HRS.                                  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>homemaker</b>   |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>           |   | 12. CITIZEN OF WHAT COUNTRY?  |
| 13. FATHER'S NAME<br><b>Wm. P. Backmiller</b>   |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Amelia Wasmus</b>   |   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                                  |  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Mr. Harry Scott - 108 Wyndhurst Ave.</b>           |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic cardiovascular disease</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |  |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |  |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  |  |   |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)              |   |
| 21. I certify that I attended the deceased from <b>Sept. 19, 1956</b> to <b>Oct. 3, 1956</b> , that I last saw the deceased alive on <b>Sept 30 1956</b> , and that death occurred at <b>11:30 A</b> M, from the causes and on the date stated above.   |                                  |  |   |   |  |   |   |
| ACTUAL SIGNATURE<br><b>A. Allan Spier</b>   |                                  |  | ADDRESS (Street, city or town, state)<br><b>4408 Loch Raven Blvd Baltimore 18, Md</b>                     |   |  |   |   |
| PHYSICIAN'S NAME (Type)<br><b>A. ALLAN SPIER</b>  |                                  |  | DATE SIGNED<br><b>10/6/56</b>   |   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10/6/56</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Friends Burial Ground</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Tucker &amp; Sons - Balto. 17 Md</b>  |                                  |  | ADDRESS   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>10/11/56</b>                        | 24b. REGISTRAR'S SIGNATURE<br><b>Thos. J. May</b> |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO GENERAL REGISTRAR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE NEW YORK PUBLIC LIBRARY

ASTEN LENOX TILDEN FOUNDATION

1891

## Reg. Dist. No.

Item 4 FilmG205 10-10-56 e

10103

# CERTIFICATE OF DEATH

282

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b>  |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. STATE<br><b>Maryland</b>  |  | b. COUNTY<br><b>St. Mary's Co.</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  | c. LENGTH OF STAY IN IB<br><b>7mths3dys</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Tall Timbers, Maryland</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SPRING GROVE STATE HOSPITAL</b>  |  |   |  | d. STREET ADDRESS<br><b>Tall Timbers, Md.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Alexander I. Sheehan</b>   |  | First Middle Last   |  | 4. DATE OF DEATH<br><b>October 2, 1956</b>  |  | Month Day Year  |  |
| 5. SEX<br><b>male</b>   |  | 6. COLOR OR RACE<br><b>white</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>unknown</b>  |  |
| 9. AGE (In years last birthday)<br><b>74 1/2</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |  | 11. IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>XXXXXX Merchant</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Store</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>XXXXXX John Sheehan</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>XXXXXX Ellen J. Bean</b>   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |  | 17. INFORMANT<br>Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH              |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour o. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Feb. 29, 1956</b> , to <b>Oct. 2, 1956</b> , that I last saw the deceased alive on <b>Oct. 2, 1956</b> , and that death occurred at <b>11:20 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>10-3-56</b><br>ACTUAL SIGNATURE <b>Stella Wachslor</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>Stella Wachslor, M. D.</b> <b>Catonsville 28, Md.</b> |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>10/6/56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Georges</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Valley Lee, Md.</b>                           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robinson Funeral Home Leonardtown</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>10/5/56</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Glen D. Hauer</b>  |  |



10104

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>3 Baltimore</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission)<br>a. STATE <u>2</u> b. COUNTY <u>3 Baltimore</u>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore 12</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore 12</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>1421 Glendale Road</u>   |                                  | d. STREET ADDRESS<br><u>1421 Glendale Road</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Otto T</u> Middle <u>Edward</u> Last <u></u>  |                                  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>22</u> Year <u>1956</u>  |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 9, 1869</u>  |
| 9. AGE (In years last birthday) <u>87</u> yrs   |                                  | IF UNDER 1 YEAR<br>Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u></u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |   |
| 13. FATHER'S NAME<br><u>W. Sheperd</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>For Dorr</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><u></u>   |   |
| 17. INFORMANT<br><u>Mrs. Rhoda J. Shannon</u>   |                                  | Address <u></u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-Renal-Vascular Disease</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u></u><br>DUE TO (c) <u></u> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 1/2 yrs</u>                                |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>  |                                  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m. <u></u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u></u>   |
| 20f. (City or town)<br><u></u>  |                                  | 20g. (County)<br><u></u>   |   |
| 20h. (State)<br><u></u>   |                                  | 20i. (City or town)<br><u></u>   |   |
| 21. I certify that I attended the deceased from <u>Feb. 20</u> , 19 <u>56</u> to <u>Oct. 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 22</u> , 19 <u>56</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.                                    |                                  |  |   |
| ACTUAL SIGNATURE <u>George E. Shannon</u>   |                                  | ADDRESS (Street, city or town, state) <u>820 Medical Arts Building Balto., Md.</u>   |   |
| DATE SIGNED <u>10/24/56</u>   |                                  | DATE SIGNED <u>10/24/56</u>  |   |
| PHYSICIAN'S NAME (Type)<br><u>Dr. George E. Shannon</u>   |                                  | PHYSICIAN'S NAME (Type)<br><u>Dr. George E. Shannon</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>10/25/56</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Greenwood Cemetery</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Funeral Home, 3000 S. Maryland</u>   |                                  | 24a. REC'D BY REGISTRAR<br><u>10/24/56</u>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><u>Mrs. G. L. Ruffin</u>  |                                  | 24c. REGISTRAR'S SIGNATURE<br><u>Mrs. G. L. Ruffin</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, the registrar, and the registrar, it should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

CT 1956

RECEIVED

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the 19th copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10088

## 10105 CERTIFICATE OF DEATH

Reg. Dist. No. 37

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH  |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED   |  |  |  |
| COUNTY <u>BALTIMORE</u>  |  | STATE <u>MARYLAND</u>  |  | STATE <u>N.Y.</u>   |  | COUNTY   |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br><u>COCKEYSVILLE</u>  |  | LENGTH OF STAY (In this place)<br><u>19 MONTHS</u>   |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>GREEN</u> |  | TOWN   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>MASONIC HOME</u>   |  |  |  | STREET ADDRESS (If rural give location)<br><u>INDIAN BROOK RD</u>                     |  |  |  |
| 3. NAME OF DECEASED (Type or Print)  |  |  |  | 4. DATE OF DEATH  |  |  |  |
| (First)<br><u>CATHERINE</u>  |  | (Middle)<br><u>E</u>   |  | (Last)<br><u>SIBLEY</u>   |  | (Year)<br><u>19 56</u>   |  |
| 5. SEX<br><u>F</u>   |  | 6. COLOR OR RACE<br><u>W</u>   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>WIDOWED</u>                    |  | 8. DATE OF BIRTH<br><u>9/18/1862</u>   |  |
| 9. AGE last birthday<br><u>94</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>                          |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>                                    |  |
| 13. FATHER'S NAME<br><u>MICHAEL THORNE</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>ISABELL L. SMITH</u>                                   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br><u>NO</u>   |  |  |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |  | 17. INFORMANT & ADDRESS<br><u>Frank L. Smith Jr</u><br><u>Cockeysville, Md</u> |  |
| 18. MEDICAL CERTIFICATION  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  | <u>15 months</u>  |  |  |  |
| IMMEDIATE CAUSE (A) <u>Arterio-Sclerotic Cardio Vascular disease</u>   |  |  |  |   |  |  |  |
| ANTECEDENT CAUSE(S) DUE TO   |  |  |  |   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)   |  |  |  |   |  |  |  |
| STATING UNDERLYING CAUSE LAST. DUE TO (C)  |  |  |  |   |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                          |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 21e. INJURY OCCURRED   |  | 21f. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>3/6</u> , 19 <u>55</u> , to <u>10/17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/17</u> , 19 <u>56</u> , and that death occurred at <u>12:10 A.M.</u> , from the causes and on the date stated above. |  |  |  |   |  |  |  |
| SIGNATURE<br><u>Walter J. Kues</u>   |  | M.D.<br><u>Cockeysville Md.</u>  |  | DATE SIGNED<br><u>10/18/56</u>  |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | DATE THEREOF<br><u>10/20/56</u>  |  | NAME OF CEMETERY OR CREMATORY<br><u>Lorraine</u>                                      |  | LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u>              |  |
| 24. REC'D BY REGISTRAR<br><u>Oct. 18, 1956</u>   |  | REGISTRAR'S SIGNATURE<br><u>Frank L. Smith Jr</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Wm Cook Inc - 1217 S. Vandalia St</u>          |  | ADDRESS  |  |

BUREAU V. B.

OCT 19 1956

RECEIVED



1

10106

10089

Reg. Dist. No.

10106

CERTIFICATE OF DEATH

10089

Reg. Dist. No.

10106

CERTIFICATE OF DEATH

10089

Reg. Dist. No.

|   |                                    |  |   |
|---|------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>701 W. Joppa Rd.</b>  |                                    | d. STREET ADDRESS <b>701 W. Joppa Rd.</b>  |   |
| 3. NAME OF DECEASED (Type or print) First <b>A.</b> Middle <b>CLARENCE</b> Last <b>SMINK</b>  |                                    | 4. DATE OF DEATH Month <b>Oct.</b> Day <b>31</b> Year <b>19 56</b>   |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>      | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Dec. 17, 1875</b>                                   |
| 9. AGE (In years last birthday) <b>80</b> yrs.  |                                    | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY <b>Hebbville, Maryland</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>Hebbville, Maryland</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME <b>Unknown</b>  |                                    | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |                                    | 16. SOCIAL SECURITY NO. <b>None</b>  |   |
| 17. INFORMANT <b>Rose Talley Smink, 701 W. Joppa Rd.</b>  |                                    | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br><b>L45A</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Hypertensive cardiovascular disease</b><br>DUE TO (c) <b>Infirmities of age</b> |                                    | INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs.</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                    | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>   |                                    | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                    | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>10/31</b> , 19 <b>55</b> to <b>10/31</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10/31</b> , 19 <b>56</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.  |                                    |  |   |
| ACTUAL SIGNATURE <b>Dr. Thomas G. Abbott</b> M.D.   |                                    | ADDRESS (Street, city or town, state) <b>4509 Liberty Heights Ave. - Balto., Md.</b>   |   |
| DATE SIGNED <b>Oct. 31, 1956</b>  |                                    |  |   |
| PHYSICIAN'S NAME (Type) <b>Thomas G. Abbott, M.D.</b>   |                                    |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 22b. DATE THEREOF <b>11/3/1956</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>  | 22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b> ADDRESS <b>4600 Liberty Heights Ave.</b>   |                                    | 24a. REC'D BY REGISTRAR <b>5</b>   | 24b. REGISTRAR'S SIGNATURE <b>Malcolm Gray</b>                          |

RECEIVED

NOV 5 1936

BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10090

.10.107

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |                                       |
|--|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY                                 |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>   |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1804 Aberdeen Road</b>   |                                  | d. STREET ADDRESS <b>1804 Aberdeen Road #4</b>  |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>SNYDER, SR.</b>   |                                  | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>12</b> Year <b>19 56</b>   |                                       |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/16/1879</b> |
| 9. AGE (In years last birthday) <b>76</b> yrs  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min  | IF UNDER 24 HRS                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Pinkerton Detective Agency Balto. Maryland</b>   |                                       |
| 11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?  |                                       |
| 13. FATHER'S NAME<br><b>John W. Snyder</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO. <b>Yes</b>  |                                       |
| 17. INFORMANT<br><b>Mr. John W. Snyder-1804 Aberdeen Road #4</b>   |                                  | Address   |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cardio-vascular renal disease</b><br>DUE TO<br>(c) <b>Hemiplegia</b>  |                                  |   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General arterio-sclerosis - hypertension</b>  |                                  |   |                                       |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |                                       |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                       |
| 20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                  | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                       |
| 20e. (City or town)  |                                  | (County) (State)  |                                       |
| 21. I certify that I attended the deceased from <b>July 27, 19 56</b> to <b>Oct-12, 19 56</b> , that I last saw the deceased alive on <b>Oct-12, 19 56</b> , and that death occurred at <b>8 P. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>8155 Loch Raven Blvd</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>Dr. Lee K Fargo</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>DR LEE K FARGO</b> |                                  |   |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                                  | 22b. DATE THEREOF <b>10/16/56</b>   |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Touhon Park Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Snyder</b> ADDRESS <b>1804 Aberdeen Road</b>   |                                  | 24a. REC'D BY REGISTRAR <b>10/15/56</b> 24b. REGISTRAR'S SIGNATURE  |                                       |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it must be filed with the Registrar of Deaths. The funeral director must also file a copy of this certificate with the Registrar of Deaths. The funeral director must also file a copy of this certificate with the Registrar of Deaths. The funeral director must also file a copy of this certificate with the Registrar of Deaths.

RECEIVED

NOV 15 1966

RECEIVED



BUREAU V. I.

OCT 18 1956

RECEIVED

10109

## 10092

Reg. Dist. No. \_\_\_\_\_

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTO</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>Md</b> b. COUNTY <b>BALTO.</b>                          |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SPARROWS POINT</b>   |  | c. LENGTH OF STAY IN lb<br><b>40 DLS</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SPARROWS POINT</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>510 D ST.</b>  |  |  |  | d. STREET ADDRESS<br><b>510 D ST.</b>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>WALTER SCOTT STEVENSON</b>  |  |  |  | 4. DATE OF DEATH Month Day Year<br><b>10-15-1956</b>  |  |   |  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>OCT. 28, 1874</b>  |  |
| 9. AGE (In years last birthday) yrs.<br><b>81</b>   |  | IF UNDER 1 YEAR Months Days Hours Min<br><b>81</b>   |  | IF UNDER 24 HRS. Hours Min<br><b>81</b>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MOULDER</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL MFGR.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>PENNA.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>HUGH STEVENSON</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY F. BROWN</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Ill yes, give war or dates of service<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>213-04-2538A</b>   |  | 17. INFORMANT Address<br><b>Address</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b><br>DUE TO<br>(c) <b>Arteriosclerotic Ht. Disease</b>  |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs</b><br><br><b>1 1/2 yrs</b><br><br><b>4 yrs</b>                                     |  |
|   |  |  |  |   |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |   |  |   |  |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year<br><b>19</b>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from June 1952, to Oct. 15, 1956, that I last saw the deceased alive on Oct. 15, 1956, and that death occurred at 11:30 P.M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>J. T. Means</b> <b>520 D St. Balt. Md.</b> <b>10/14/56</b><br>ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>J. T. Means</b> |  |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  | 22b. DATE THEREOF <b>10-18-56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>DAK LAWN</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>BALTO. CO., MD</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Walter R. Rindley, Newbold, Md.</b>  |  |  |  | 24a. REC'D BY REGISTRAR DATE<br><b>10-10-56</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Dawson L. Farber</b>   |  |

RECEIVED

OCT 18 1956

BUREAU V



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10093

Reg. Dist. No.

10110

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Overlea</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Overlea</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>5 Willow Ave.</u>   |                                  | d. STREET ADDRESS<br><u>5 Willow Ave.</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Laura</u> Middle <u>R.</u> Last <u>Steward</u>   |                                  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>30</u> Year <u>1956</u>  |   |
| 5 SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Oct. 31, 1885</u>  |
| 9 AGE (In years last birthday)<br><u>70</u> yrs  |                                  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>At Home</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Westminster, Md.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>  |   |
| 13. FATHER'S NAME<br><u>James C. Mobley</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Myra Lykens</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>   |   |
| 17. INFORMANT<br><u>Mr. Charles W. Steward</u>   |                                  | Address<br><u>5 Willow Ave.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute leukemia</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinoma</u><br>DUE TO (c) <u>Primary leukemia</u> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>  </u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>56</u> , to <u>Oct 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 30</u> , 19 <u>56</u> , and that death occurred at <u>8:20</u> M, from the causes and on the date stated above.   |                                  |  |   |
| ACTUAL SIGNATURE <u>[Signature]</u>  |                                  | M.D. <u>Stor [Signature]</u>   |   |
| PHYSICIAN'S NAME (Type)<br><u>M. J. Steward M.D.</u>   |                                  | ADDRESS (Street, city or town, state)<br><u>  </u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>Nov. 1, 1956</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mount Olive</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Randallstown, Md.</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Lassahn Funeral Home</u>  |                                  | ADDRESS<br><u>7401 Belair Rd.</u>  |   |
| 24a. REC'D BY REGISTRAR<br><u>  </u>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Mrs. A. L. [Signature]</u>  |   |

RECEIVED

NOV 1 1956

BUREAU V. S.

1  
#

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10111

## CERTIFICATE OF DEATH

10094

Reg. Dist. No.

30

|  |   |  |   |
|--|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION <b>Catonsville Convalescent Home</b><br><b>315 Ingleside Avenue</b>  |   | d. STREET ADDRESS<br><b>703 Hillen Road</b>  |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>Susanna Virginia Swam</b>  |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>25</b> Year <b>19 56</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 23, 1871</b>                                    |
| 9. AGE (In years last birthday)<br><b>84</b> yrs.  |   | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dress Maker</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |   |
| 13. FATHER'S NAME<br><b>William Henry Swam</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Clara Jane Painter</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>Miss Bertha N. Swam</b>  |   | Address <b>Baltimore 17</b><br><b>151 W. Lafayette Avenue</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b><br><b>19221</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c) <b>Arteriosclerotic Cardio Vascular Disease</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>12 yrs.</b>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>Sept 21, 1954</b> to <b>Oct. 25, 1956</b> , that I last saw the deceased alive on <b>Oct. 24, 1956</b> , and that death occurred at <b>9 A. M.</b> from the causes and on the date stated above.  |   |  |   |
| ACTUAL SIGNATURE <b>Joshua H. Armacost</b> M.D.  |   | ADDRESS (Street, city or town, state) <b>6419 Windsor Mill Road</b> DATE SIGNED  |   |
| PHYSICIAN'S NAME (Type) <b>JOSHUA H. ARMACOST</b>  |   | <b>Baltimore 7 Maryland</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>Oct. 27, 1956</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's (Hampden)</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Burgee Funeral Home</b><br><b>3631 Falls Road</b><br><b>Ronald F. Burgee</b>  |   | 24a. REC'D BY REGISTRAR<br><b>Oct. 29, 1956</b><br><b>T. E. Harry</b>  |   |

BUREAU V. S.

OCT 30 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10112 CERTIFICATE OF DEATH

10095 44

Reg. Dist. No.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Fort Howard</u><br>c. LENGTH OF STAY IN 1b<br><u>37 Days</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Veterans Administration Hospital</u>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY _____<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u><br>d. STREET ADDRESS<br><u>2702 Pelham Avenue</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| <b>3. NAME OF DECEASED</b> (Also: <u>ROBERT LOUIS</u> )<br>(Type or print) <span style="float: right;">Middle R. SWEITZER</span><br><b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>4</u> Year <u>1956</u>  |  |  |  | <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>8. DATE OF BIRTH</b> <u>August 10, 1895</u> <b>9. AGE</b> (In years last birthday) <u>61</u> yrs. <b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____   |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Fireman - city- retired</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Fire Department</u> <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Baltimore, Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U. S. A.</u>  |  |  |  | <b>13. FATHER'S NAME</b> <u>Charles Sweitzer</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Rose Siefert</u>   |  |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>Yes</u> <u>WW I</u> <b>16. SOCIAL SECURITY NO.</b> <u>217-26-6847</u> <b>17. INFORMANT</b> <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u>   |  |  |  | <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u><br>DUE TO <u>RHEUMATIC HEART DISEASE WITH AORTIC STENOSIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____<br><b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____  |  |  |  | <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>VA</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____   |  |  |  |
| <b>21. I certify that I attended the deceased from <u>August 28, 1956</u>, to <u>October 4, 1956</u>, and that death occurred at <u>11:50 A.M.</u> from the causes and on the date stated above.</b><br>ADDRESS (Street, city or town, state) _____ DATE SIGNED _____<br><b>ACTUAL SIGNATURE</b> <u>James H. Nolan</u> <b>M.D. V.A.H., FORT HOWARD, MARYLAND</b> <b>10/4/56</b><br><b>PHYSICIAN'S NAME (Type)</b> <u>JAMES H. NOLAN, M.D.</u> |  |  |  |  |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>   |  | <b>22b. DATE THEREOF</b><br><u>10-4-56</u> |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Oak Lawn Cemetery</u>  |  | <b>22d. LOCATION (City, town, or county)</b> <u>Baltimore, Maryland</u> <b>(State)</b> _____ |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> _____ <b>ADDRESS</b> <u>4210 Belair Rd., Balto. Md.</u>   |  |  |  | <b>24a. REC'D. BY REGISTRAR</b> _____ <b>24b. REGISTRAR'S SIGNATURE</b> <u>Lawson L. Farber</u>  |  |  |  |

Ullrich Funeral Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 21 hours after death. Page 1  
 may be retained by the hospital or attending physician.  
 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3rd AVENUE

OFFICE

100-100000

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10113

## CERTIFICATE OF DEATH

10096

Reg. Dist. No.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY                                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Caton Ridge Nursing Home-329 Harlem Lane</b>   |   | d. STREET ADDRESS<br><b>1825 E. 31st St.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARGARET</b> Middle <b>TALL</b> Last  |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>11</b> Year <b>1956</b>  |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 4, 1866</b>                                |
| 9. AGE (In years last birthday)<br><b>90</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife (rtd)</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>John H. Riehl</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Catherine H. --</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Mr. J. H. Riehl, Jr.</b>  |   | Address<br><b>4439 Wickford Rd.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>arterio sclerotic heart disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b><br><b>yo</b>           |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                    |
| 21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>53</b> , to <b>Oct</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Oct 11</b> , 19 <b>56</b> , and that death occurred at <b>9:15</b> M. from the causes and on the date stated above.   |   |   |   |
| ACTUAL SIGNATURE<br><b>Ernest C. Brown</b>  |   | M.D. <b>1101 N Calvert St, Balt-2</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>Ernest C. Brown</b>   |   | DATE SIGNED<br><b>10/13/56</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>10/13/56</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cem.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Pikesville, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Lickner &amp; Sons - Balt</b>   |   | 24a. REC'D BY REGISTRAR<br><b>10/13/56</b>  |   |
| ADDRESS<br><b>Balto 17 Md</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>J. E. Lanyo</b>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be received by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 15 1900

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers between pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10114

## CERTIFICATE OF DEATH

10097 45

Reg. Dist. No.

|  |                              |   |  |   |  |   |  |
|--|------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Balto.</u> MARYLAND  |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>b. STATE <u>Md.</u> c. COUNTY <u>Baltimore</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Middle River</u>  |                              |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Middle River</u>                                 |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                              |   |  | d. STREET ADDRESS<br><u>Lynnwood Pk.</u>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>EMMA</u> Middle <u>VA.</u> Last <u>TAYLOR</u>  |                              |   |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>20</u> Year <u>1956</u>   |  |   |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 21, 1890</u> | 9. AGE (In years last birthday)<br><u>66</u> yrs  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House-keeper</u>   |                              |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own-Home</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Balto.</u>                |  |
| 10c. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |                              |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><u>John Menzel</u>  |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Carrie Smith</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                              |   |  | 16. SOCIAL SECURITY NO.   |  |   |  |
| 17. INFORMANT<br><u>Albert Taylor</u>  |                              |   |  | Address <u>Towson 4, Md.</u><br><u>501 Overbrook Rd</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial infarction</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary sclerosis</u><br>DUE TO (c) <u>10 years</u> |                              |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hour</u>                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |                              |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                               |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    |  |
|  |                              |   |  | 20f. (City or town)   |  | (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>April 19, 1946</u> , to <u>Oct 20, 1956</u> , that I last saw the deceased alive on <u>Oct 20, 1956</u> , and that death occurred at <u>230 P</u> M, from the causes and on the date stated above   |                              |   |  |   |  |   |  |
| DECEASED SIGNATURE<br><u>A. H. Kolodny</u>   |                              |   |  | ADDRESS (Street, city or town, state)<br><u>1825 Eastern Blvd</u>   |  |   |  |
| DATE SIGNED<br><u>Oct 21, 1956</u>   |                              |   |  |   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><u>John G. Connelly</u>   |                              |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                              | 22b. DATE THEREOF<br><u>10-24-56</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Landon Pk.</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Balto.</u> <u>Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John G. Connelly</u>  |                              |   |  | ADDRESS<br><u>Essex Md.</u>   |  | 24a. REC'D BY REGISTRAR<br><u>OCT 24 1956</u>                             |  |
|  |                              |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Edith H. Hays</u>  |  |   |  |

BUREAU W. S.

OCT 21 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1009838

10115

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Baltimore</i> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>1</i>                       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ruxton</i>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ruxton</i>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1218 Boyce Ave</i>   |  | d. STREET ADDRESS <i>1218 Boyce Ave</i>  |   |
| 3. NAME OF DECEASED (Type or print) First <i>JULIA</i> Middle <i>MAY</i> Last <i>TAYLOR</i>  |  | 4. DATE OF DEATH Month <i>Oct</i> Day <i>14</i> Year <i>1956</i>   |   |
| 5. SEX <i>Female</i>   | 6. COLOR OR RACE <i>White</i>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>March 25, 1876</i>                                    |
| 9. AGE (In years last birthday) <i>80 yrs</i>  |  | IF UNDER 1 YEAR Months Days Hours Min  | IF UNDER 24 HRS   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>  |   |
| 11. BIRTHPLACE (State or foreign country) <i>Warren, Balto. Co.</i>  |  | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |   |
| 13. FATHER'S NAME <i>John H. Taylor</i>  |  | 14. MOTHER'S MAIDEN NAME <i>Sarah E. Green</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <i>none</i>  |   |
| 17. INFORMANT <i>Mrs. Spilker</i>  |  | Address <i>- Same</i>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary artery occlusion</i><br><i>4201</i><br>DUE TO (b) <i>Arteriosclerotic cardiovascular disease</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (c) |  |  | INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>                            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. p. m. <i>19</i>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                      |
| 21. I certify that I attended the deceased from <i>July 12, 1956</i> , to <i>Oct 14, 1956</i> , that I last saw the deceased alive on <i>Oct 11, 1956</i> , and that death occurred at <i>2:35 PM</i> , from the causes and on the date stated above.  |  |  |   |
| ACTUAL SIGNATURE <i>THADDEUS C. SWINSKI</i>  |  | ADDRESS (Street, city or town, state) <i>17 W. PENNA. AVE. TOWSON 4 MD</i>   |   |
| PHYSICIAN'S NAME (Type) <i>THADDEUS C. SWINSKI</i>   |  | DATE SIGNED <i>Oct 15, 1956</i>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  | 22b. DATE THEREOF <i>Oct 17, 1956</i>  | 22c. NAME OF CEMETERY OR CREMATORY <i>Poplar Grove Cem.</i>  | 22d. LOCATION (City, town, or county) (State) <i>Baltimore County Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins</i>   |  | ADDRESS <i>4905 York Road</i>  |   |
| 24a. REC'D BY REGISTRAR <i>Oct 17, 1956</i>  |  | 24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be released by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO GENERAL PUBLIC: This certificate is detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 18 1956

BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10116

CERTIFICATE OF DEATH

10099

Reg. Dist. No.

|  |  |   |  |  |  |   |   |
|--|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY                              |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>7 days</b>   |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Veterans Administration Hospital</b>  |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |  |   |   |
| f. STREET ADDRESS<br><b>1007 Sharp Street</b>  |  |   |  | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>AARON E THOMAS</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>9</b> Year <b>19 56</b>  |  |   |   |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Colored</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8/3/90</b>   |   |
| 9. AGE (In years last birthday)<br><b>66</b> yrs.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Janitor</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Gas &amp; Electric Co</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>     |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 13. FATHER'S NAME<br><b>Aaron Thomas</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Cassie (Maiden name unknown)</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>Yes</b>  |  | 16. SOCIAL SECURITY NO<br><b>212-05-5122</b>  |  | 17. INFORMANT<br><b>Clin Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF PROSTATE WITH GENERALIZED METASTASIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY<br>Hour <b>19</b> Month, Day, Year<br>p. m.  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>October 2, 19 56</b> , to <b>October 9, 19 56</b> , that I saw the deceased alive on <b>October 9, 19 56</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.  |  |   |  |  |  |   |   |
| ACTUAL SIGNATURE <b>Donald D. Mark</b> M.D.  |  |   |  | ADDRESS (Street, city or town, state)<br><b>VAH, FORT HOWARD, MARYLAND</b>   |  | DATE SIGNED<br><b>10/10/56</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>DONALD D. MARK, M.D.</b>   |  |   |  |  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>10/12/56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles F. Law</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>DATE 10/10/56</b>  |  |   |   |
| 24b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |   |   |

BUREAU V. S.

OCT 15 1956

RECEIVED

10117

10117

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10100 44

Reg. Dist. No.

|  |                                    |  |   |
|--|------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>   |                                    | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY  |   |
| c. LENGTH OF STAY IN 1b<br><b>77 Days</b>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Veterans Administration Hospital</b>  |                                    | d. STREET ADDRESS<br><b>1821 Rayner Avenue</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ELLIS</b> Middle Last <b>THOMAS</b>  |                                    | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>2</b> Year <b>19 56</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>July 24, 1895</b>  |
| 9. AGE (In years last birthday)<br><b>61</b> yrs.  |                                    | IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>12</b>  | IF UNDER 24 HRS.<br>Hours <b>19</b> Min <b>56</b>                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Janitor</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel Company</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Prince Edward Co., Virginia</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                    | 13. FATHER'S NAME<br><b>Unknown</b>  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |                                    | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Yes</b> <b>WW I</b>  |   |
| 16. SOCIAL SECURITY NO.<br><b>213-07-1093</b>  |                                    | 17. INFORMANT<br><b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LEFT MAXILLARY SINUS</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>LOBULAR PNEUMONIA</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b><br><b>UNKNOWN</b> |                                    | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.<br>20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>July 17, 1956</b> , to <b>October 2, 1956</b> , and that death occurred at <b>5:40 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>VAH, FORT HOWARD, MARYLAND</b><br>DATE SIGNED<br><b>10/3/56</b>  |                                    |  |   |
| ACTUAL SIGNATURE<br><b>Donald D. Mark</b><br>PHYSICIAN'S NAME (Type)<br><b>DONALD D. MARK, M.D.</b>  |                                    |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                    | 22b. DATE THEREOF<br><b>10-8-56</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cemetery</b>   |                                    | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wayne O. Wilson</b>   |                                    | 24a. REC'D BY REGISTRAR<br><b>15</b><br>24b. REGISTRAR'S SIGNATURE<br><b>1956</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, the registrar may detach for use as the burial-transit permit. Then please remove carbon papers and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

DOULEAU A

CT 5 1956

RECEIVED  
JAN 11 1957



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your file. If burial, cremation, or removal, file pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 11/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10101 30  
282

10118

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's Co.</b>           |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>18yrs10mth</b>  |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Addie</b> Middle <b>R.</b> Last <b>Tippett</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>29</b> Year <b>1956</b>  |  |  |   |
| 5. SEX<br><b>female</b>  |  | 6. COLOR OR RACE<br><b>white</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 6, 1884</b>                             |   |
| 9. AGE (In years last birthday)<br><b>72 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>29</b>   |  | IF UNDER 24 HRS.<br>Hours <b>12</b> Min. <b>56</b>  |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>       |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |  |  |   |  |  |   |
| 13. FATHER'S NAME<br><b>unknown</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>  |  | 17. INFORMANT<br>Address <b>Records: SPRING GROVE STATE HOSPITAL</b>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary heart failure</b><br><b>Arteriosclerotic cardiovascular disease</b><br><b>404.7</b> DUE TO <b>Multiple conditions</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture right hip. Accident</b><br>DUE TO (c) <b>Fracture right hip. Accident</b> |  |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pt. fell to floor on July 13, 1956 sustaining a fracture of the right hip.</b> |  |   |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>4:30 a.m. 7-13-56 19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Hospital</b>   |  | 20f. (City or town) (County) (State)<br><b>Catonsville 28, Md.</b> |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .               |  |  |  |   |  |  |   |
| ACTUAL SIGNATURE <i>George M. Kieffer</i>  |  |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |   |
| EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>   |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |   |
|  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF  |  | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or county) (State)                      |   |
| <b>Burial</b>  |  | <b>11/1/56</b>   |  | <b>Trinity</b>  |  | <b>St. Mary's Co. Md.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>William Mattingly</i>   |  |  |  | ADDRESS<br><i>London, Md.</i>   |  | 24a. REC'D BY REGISTRAR<br><b>DATE 10/31/56</b>                    |   |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><i>Dean D. Busser</i>   |  |  |   |

RECEIVED

NOV 2 1956

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10102

Reg. Dist. No. 41

9978

|   |   |   |   |
|---|---|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY</span>                           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |   | d. STREET ADDRESS <b>2927 Yorkway Rd.</b>   |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>Benny Abedine Turani Jr.</b>   |   | <b>4. DATE OF DEATH</b><br>Month <b>October</b> Day <b>10</b> Year <b>1956</b>  |   |
| <b>5. SEX</b><br><b>Male</b>  | <b>6. COLOR OR RACE</b><br><b>White</b>   | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>                    | <b>8. DATE OF BIRTH</b><br><b>JUNE 21, 1956</b>                         |
| <b>9. AGE</b> (In years last birthday) <b>3 1/2</b> yrs.  |   | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)   |   |
| <b>11. BIRTHPLACE</b> (State or foreign country) <b>STUEBENVILLE, OHIO</b>  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>   |   |
| <b>13. FATHER'S NAME</b><br><b>Benny Abedine Turani Sr.</b>   |   | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Marilyn Hall</b>  |   |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown)  |   | <b>16. SOCIAL SECURITY NO.</b>  |   |
| <b>17. INFORMANT</b><br><b>BENNY A. TURANI SR.</b>  |   | <b>Address</b>  |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><b>PART I. DEATH WAS CAUSED BY:</b><br><b>IMMEDIATE CAUSE (a)</b> <b>Aspiration of Vomitus</b><br><b>921.0 DUE TO</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b><br><b>DUE TO (c)</b>   |   |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b>                                 |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>  |   |   |   |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/><br><b>CAUSE OF DEATH.</b>   |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>Vomited and aspirated.</b>  |   |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour <b>10/10 19</b>  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>  | <b>20f. (City or town) (County) (State)</b><br><b>Dundalk Balto. Md</b> |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/> |   |   |   |
| <b>ACTUAL SIGNATURE</b> <i>William V. Lovitt</i>  |   | <b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> |   |
| <b>EXAMINER'S NAME (Type)</b><br><b>William V. Lovitt, M.D.</b>   |   | <b>DATE SIGNED</b><br><b>10/10/56</b>   |   |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>BURIAL</b>   |   | <b>22b. DATE THEREOF</b><br><b>10-12-56</b>   |   |
| <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Oak Lawn Cemetery</b>   |   | <b>22d. LOCATION (City, town, or county) (State)</b><br><b>BALTIMORE CO. MARYLAND</b>   |   |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><i>Walter J. Proddy</i>  |   | <b>24a. REC'D BY REGISTRAR</b><br><b>DATE</b> <b>Oct 15 1956</b>  |   |
| <b>ADDRESS</b><br><b>Dundalk, Md</b>  |   | <b>24b. REGISTRAR'S SIGNATURE</b><br><i>Tom Kelly</i>   |   |

THIS MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your file. The Registrar of the Department of Health, Baltimore, Maryland, will register the death and issue the burial or cremation permit. File pages 1 and 2 with the Registrar of the Department of Health, Baltimore, Maryland, for removal.

BUREAU V. S.

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 101119 CERTIFICATE OF DEATH

10103  
Reg. Dist. No. 33

|   |  |  |   |   |   |  |   |
|---|--|--|---|---|---|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>  |  |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission)<br>a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Owings Mills</u>   |  |  | c. LENGTH OF STAY IN 1b<br><u>16 Yrs.</u> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Owings Mills</u> |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Rosewood Lane</u>  |  |  |   | d. STREET ADDRESS<br><u>Rosewood Lane</u>   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Edna</u> Middle <u>M.</u> Last <u>Turnbaugh</u>  |  |  |   | <b>4. DATE OF DEATH</b><br>Month <u>Oct</u> Day <u>6</u> Year <u>1956</u>   |   |  |   |
| <b>5. SEX</b><br><u>Female</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u>  |   | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>                    |   | <b>8. DATE OF BIRTH</b><br><u>July 28, 1898</u>                                  |   |
| <b>9. AGE</b> (In years last birthday) <u>58</u> yrs  |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u> |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Housewife</u>  |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Maryland</u>              |   |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>   |  |  |   |   |   |  |   |
| <b>13. FATHER'S NAME</b><br><u>Jacob Morris</u>   |  |  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Eliy Lytle</u>  |   |  |   |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)<br><u>no</u>  |  | <b>16. SOCIAL SECURITY NO</b><br><u>217-09-7406</u>  |   | <b>17. INFORMANT</b> Address<br><u>William F. Turnbaugh, Owings Mills, Md.</u>  |   |  |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of left lung</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO (c) _____ |  |  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 mos</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |  |  |   |   |   |  |   |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |   |   |  |   |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)   |  |  |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour <u>a. m.</u> <u>19</u>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>       |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |   | <b>20f. (City or town)</b> (County) (State)                                      |   |
| <b>21. I certify that I attended the deceased from</b> <u>1</u> <b>1953</b> , to <u>Oct 6</u> <b>1956</b> , that I last saw the deceased alive on <u>6 Oct</u> <b>1956</b> , and that death occurred at <u>7:00</u> <b>A. M.</b> from the causes and on the date stated above                                   |  |  |   |   |   |  |   |
| <b>ACTUAL SIGNATURE</b> <u>Paul H Royse</u> M.D.  |  |  |   | <b>ADDRESS</b> (Street, city or town, state) <u>Pikesville 8 Md</u> <b>DATE SIGNED</b> <u>6 Oct 56</u>  |   |  |   |
| <b>PHYSICIAN'S NAME</b> (Type) <u>PAUL H ROYSE MD.</u>  |  |  |   |   |   |  |   |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  | <b>22b. DATE THEREOF</b><br><u>Oct, 8, 56</u>  |   | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Pleasant Grove</u>  |   | <b>22d. LOCATION</b> (City, town, or county) (State)<br><u>Baltimore Co. Md.</u> |   |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS<br><u>J.F.Eline &amp; Sons Reisterstown, Md.</u>  |  |  |   | <b>24a. REC'D BY REGISTRAR</b> DATE<br><u>10-6-56</u>   |   | <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Mary B. Eline</u>                        |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

OCT 9 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10104 38

Reg. Dist. No.

10120

|  |                              |   |  |   |   |   |                                |
|--|------------------------------|---|--|---|---|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>  |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY |   |   |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |                              | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>                        |   |   |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |                              |   |  | d. STREET ADDRESS<br><b>1813 N. Mount Street</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| 3. NAME OF<br>(Type or print)<br>First <b>CLAUDE</b> Middle <b>DONALD</b> Last <b>URQUHART</b>   |                              |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>24</b> Year <b>19 56</b>  |   |   |                                |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>N</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 27, 1902</b> |   | 9. AGE (In years last birthday)<br><b>54</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Custodian</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Consolidated Cold Storage</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Phoebe, Va.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                |
| 13. FATHER'S NAME<br><b>John Urquhart</b>  |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Alice Cross</b>  |   |   |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no or unknown) <b>No</b><br>(If yes, give war or dates of service)   |                              | 16. SOCIAL SECURITY NO.<br><b>214-03-0358</b>   |  | 17. INFORMANT<br>Address<br><b>Mrs. Gertrude Urquhart - 1813 N. Mount Street</b>  |   |   |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>440,1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)   |                              |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>   |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |   |  |   |   |   |                                |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |                                |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                              | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |                                |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                              |   |  |   |   |   |                                |
| ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>   |                              |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   |                                |
| EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>   |                              |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |                                |
|  |                              |   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |   |   |                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 22b. DATE THEREOF<br><b>10/28/56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Greenwood</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Trenton, New Jersey</b>                       |                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles R. Law</b>  |                              |   |  | ADDRESS<br><b>802 Madison Avenue</b>  |   | 24a. REC'D BY REGISTRAR<br><b>DATE 28-10-56</b>   |                                |
|  |                              |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Robert Gray</b>  |   |   |                                |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 14 days after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. The funeral director must register the burial, cremation, or removal.

BUREAU V. S.

1906 OCT

RECEIVED



CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY                              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>11 Days</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Veterans Administration Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>Box 202</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JACOB</b> Middle <b>G.</b> Last <b>WAGNER</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>12</b> Year <b>19 56</b>   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>11/7/92</b>                                      |  |
| 9. AGE (In years last birthday)<br><b>63</b> yrs   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plasterer</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>MASON</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Jerry Wagner</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Gimmel</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>Yes</b>  |  | 16. SOCIAL SECURITY NO.<br><b>212-28-4359</b>   |  | 17. INFORMANT<br><b>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHO-PNEUMONIA DIFFUSE MULTIPLE PULMONARY ABSCESSSES</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b>   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)   |  |   |  | 20g. (City or town) (County) (State)   |  |   |  |
| 21. I certify that I attended the deceased from <b>October 1, 1956</b> to <b>October 12, 1956</b> and that death occurred at <b>6:10 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>C. J. Papastrat M.D.</b>   |  |   |  | M.D. <b>VAH, Fort Howard, Md.</b>  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M.D.</b>   |  |   |  | VAH, Fort Howard, Md.  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>10/16/56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Edwards Chapel Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Annapolis, Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John E. Taylor</b>  |  |   |  | ADDRESS<br><b>John E. Taylor Funeral Home, Duke of Gloucester</b>  |  | 24a. REC'D BY REGISTRAR<br><b>15 1956</b>                               |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Dawson D. Sawyer</b>  |  |   |  |  |  |   |  |

BUROU V. S.

OCT 1960

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 1  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. 3 copies should be detached for use as the burial-transit permit. Then please return carbon papers, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9979

## CERTIFICATE OF DEATH

10106 4/1

Reg. Dist. No.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTO</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>                       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK (22)</u>   |   |
| c. LENGTH OF STAY IN 1b <u>17 YRS.</u>   |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>65 DUNDALK AVE</u>   |  | d. STREET ADDRESS <u>65 DUNDALK AVE</u> <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO                      |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET MULLER WAGNER</u>  |  | 4. DATE OF DEATH Month Day Year <u>10-24-1956</u>  |   |
| 5. SEX <u>FEM.</u>   | 6. COLOR OR RACE <u>WHITE</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 15, 1867</u>                               |
| 9. AGE (In years last birthday) <u>87</u> yrs.   |  | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>(P) MULLER</u>  |  | 14. MOTHER'S MAIDEN NAME <u>VINK.</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <u>NONE</u>  |   |
| 17. INFORMANT <u>HENRY W. WAGNER</u>   |  | Address <u>SAME ADDRESS</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular Renal Disease</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u><br>DUE TO (c) <u>—</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>—</u>                           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>   | 20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                |
| 21. I certify that I attended the deceased from <u>10-22</u> , 19 <u>56</u> , to <u>10-24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-24</u> , 19 <u>56</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.                                      |  |  |   |
| ACTUAL SIGNATURE <u>Jack C. Collins</u>  |  | ADDRESS (Street, city or town, state) DATE SIGNED <u>2200 N. York Balt 22 10-26-56</u>   |   |
| PHYSICIAN'S NAME (Type) <u>JACK C COLLINS</u>  |  | <u>BALTIMORE</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  | 22b. DATE THEREOF <u>10-27-56</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>PAK LAWN</u>   | 22d. LOCATION (City, town, or county) (State) <u>BALTO. Co. MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Arthur Bradley, Dundalk, MD</u>   |  | 24a. REC'D BY REGISTRAR DATE <u>NOV 30 1956</u>  |   |
|  |  | 24b. REGISTRAR'S SIGNATURE <u>Lawrence L. Lasker</u>   |   |

RECEIVED

1966

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10122

## CERTIFICATE OF DEATH

10107

Reg. Dist. No.

44

|  |   |  |  |   |   |
|--|---|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTO.</u> MARYLAND  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Balto.</u> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BOWLEYS CREEK</u>   |   |  | c. LENGTH OF STAY IN 1b<br><u>40 yrs</u>   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |   |  | d. STREET ADDRESS<br><u>Cummins St. No. 12 X 52</u>  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Henry</u> Middle <u>G</u> Last <u>Heibel</u>   |   |  | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>23</u> Year <u>1956</u>   |   |   |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>white</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Oct. 28 - 1885</u>  | 9. AGE (In years last birthday)<br><u>70</u> yrs.           | IF UNDER 1 YEAR<br>Months <u>2</u> Days <u>3</u> Hours <u>19</u> Min <u>26</u>                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>factory worker</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>retired</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Germany</u> |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |   |  | 13. FATHER'S NAME<br><u>Henry Heibel</u>   |   |   |
| 14. MOTHER'S MAIDEN NAME<br><u>?</u>   |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>               |   |   |
| 16. SOCIAL SECURITY NO.  |   |  | 17. INFORMANT<br><u>William M. Stanchum</u> Address <u>Grove</u>   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>541.0</u> DUE TO <u>GASTRIC HEMORRHAGE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Peptic Ulcer</u> DUE TO (c) <u>?</u> |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 Day</u><br><u>3 Mo.</u>                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA LARYNX</u>  |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town)  | (County)  | (State)   |
| 21. I certify that I attended the deceased from <u>JUNE</u> , 1956, to <u>Oct 23</u> , 1956, that I last saw the deceased alive on <u>Oct 23</u> , 1956, and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.  |   |  |  |   |   |
| ACTUAL TIME <u>Louis Semenovoff</u>  |   | ADDRESS (Street, city or town, state) <u>1437 Funlage Ave</u>  |  | DATE SIGNED <u>10/25/56</u>                                 |   |
| PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOVFF</u>   |   | <u>Balto Md</u>  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF<br><u>10-26-56</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>mt. Olivet</u>  | 22d. LOCATION (City, town, or county)  | (State)   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John G. Connolly</u>  |   | ADDRESS<br><u>Cas. P. Md.</u>  | 24a. REC'D BY REGISTRAR<br><u>29 1956</u>  | 24b. REGISTRAR'S SIGNATURE<br><u>Lawson L. Farley</u>       |   |

BUREAU V. S.

1956

RECEIVED  
FEB 14 1956

## 10123 CERTIFICATE OF DEATH

Reg. Dist. No.

30

|   |                                  |  |   |  |  |
|---|----------------------------------|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Michael L. Weaver</i>   |                                  |  | 2. DATE OF DEATH <i>Oct. 5, 1956</i>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Baltimore County</i>                                   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Maryland</i><br>B. COUNTY <i>1</i> |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>House in the Pine Nursing Home</i>                            |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore</i>  |  |  |
| c. Length of stay in Baltimore <i>Life</i><br>Yrs. <i></i><br>Mos. <i></i><br>Days <i></i>                  |                                  |  | D. STREET ADDRESS (If rural, give location)<br><i>2405 East Federal Street</i>  |  |  |
| 5. SEX<br><i>Male</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i>  | 8. DATE OF BIRTH<br><i>Nov. 6, 1894</i>   |  | 9. AGE (In years last birthday) <i>61 yrs.</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Guard</i> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Globe Detective Agency</i> |   | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore, Md.</i> |  |
| 13. FATHER'S NAME<br><i>William E. Weaver</i>   |                                  |  | 12. CITIZENSHIP OF WHAT COUNTRY?<br><i>U. S. A.</i>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>No</i>                              |                                  | 16. SOCIAL SECURITY NO.<br><i>213-12-0486</i>                      |   | 17. INFORMANT<br><i>Florence E. Daniels</i>                        |  |
|   |                                  |  |   | ADDRESS<br><i>2405 E Federal St</i>                                |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>unknown</i> |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Carcinoma of lung &amp; bronchus in</i> |  |  |
| (A) DUE TO   |  |  |
| ANTECEDENT CAUSES  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i></i>   |  |  |
| (B) DUE TO   |  |  |
| (C) DUE TO   |  |  |

|  |  |  |
|--|--|--|
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i></i> |  |  |
|--|--|--|

|  |  |   |  |  |
|--|--|---|--|--|
| IF OPERATION WAS RELATED TO PART OF DEATH, ENTER IN PART 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY |  | 19A. DATE OF OPERATION  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20. AUTOPSY?<br><input type="checkbox"/> |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?                       |  |

22. I certify that (I) (this hospital) attended the deceased from *30 June 55* to *5 Oct 56*, that (I) (we) last saw the deceased alive on *4 Oct 56*, and that death occurred at *7* m., from the causes and on the date stated above.

|  |  |                                     |
|--|--|-------------------------------------|
| 23A. SIGNATURE<br><i>William E. Weaver</i> | 23B. ADDRESS<br><i>1513 N. Milford Ave</i> | 23C. DATE SIGNED<br><i>5 Oct 56</i> |
|--|--|-------------------------------------|

|  |  |   |  |
|--|--|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i> | 24B. DATE<br><i>Oct 8 1956</i>               | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore Cemetery</i> | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Md.</i> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>Oct 6, 1956</i>     | REGISTRAR'S SIGNATURE<br><i>W. E. Weaver</i> | 25. FUNERAL DIRECTOR<br><i>John E. Miller</i>                   |  |
|  |  | ADDRESS<br><i>2431 E. Oliver St</i>                             |  |

THIS IS A PERMANENT RECORD. PLEASE TYPE OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

BUREAU W. B.

CT 9 1999

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10124

## CERTIFICATE OF DEATH

10109

Reg. Dist. No. 30

|  |                                  |   |                                    |   |   |   |                                  |
|--|----------------------------------|---|------------------------------------|---|---|---|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY |   |   |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |                                  |   |                                    | c. LENGTH OF STAY IN 1b<br><b>5mths 6 dys</b>   |   |   |                                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>SPRING GROVE STATE HOSPITAL</b>  |                                  |   |                                    | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore, Maryland</b>              |   |   |                                  |
| d. STREET ADDRESS<br><b>2310 East Chase Street - Balto.</b>  |                                  |   |                                    | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |   |   |                                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Harry</b> Middle <b>Weinberg</b> Last <b>Weinberg</b>  |                                  |   |                                    | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>24</b> Year <b>19 56</b>  |   |   |                                  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>unknown</b> | 9. AGE (In years lay birth day)<br><b>68?</b> yrs   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS<br>Months Days Hours Min.                         |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Russia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>Russia</b>                     |                                  |
| 13. FATHER'S NAME<br><b>unknown</b>  |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |   |   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |                                    | 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>  |   |   |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br><b>found</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis, severe.</b> DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) |                                  |   |                                    |   |   |   | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                |   |   |                                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                              |                                  |
| 21. I certify that I attended the deceased from <b>Aug. 6, 1956</b> , to <b>Oct. 24, 1956</b> , that I last saw the deceased alive on <b>Oct. 24, 1956</b> , and that death occurred at <b>9:00a M.</b> from the causes and on the date stated above.  |                                  |   |                                    |   |   |   |                                  |
| ACTUAL SIGNATURE <b>Stella Wachster</b>  |                                  |   |                                    | M.D. <b>SPRING GROVE STATE HOSPITAL 10-24-56</b>  |   |   |                                  |
| PHYSICIAN'S NAME (Type) <b>Stella Wachster, M. D.</b>  |                                  |   |                                    | <b>Catonsville 28, Maryland</b>   |   |   |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>10-25-1956</b>  |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Windsor Hill Def</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Balto Md.</b> |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Jack Lewis Inc</b>  |                                  |   |                                    | ADDRESS <b>Balto Md</b><br><b>2100 Eastern Pl.</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>10/26/56</b>                   |                                  |
|  |                                  |   |                                    | 24b. REGISTRAR'S SIGNATURE<br><b>Victor C Harry</b>   |   |   |                                  |

3 1/2 000000

1056

QED

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## 10125 CERTIFICATE OF DEATH

Reg. Dist. No. 5

10110

|  |                                  |  |                                     |
|--|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH:<br>COUNTY <u>BALTO.</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>MD.</u> COUNTY <u>AA.</u>                                   |                                     |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>CATONSVILLE</u>              |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>LOTHIAN</u>                        |                                     |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>House in The Pines</u>                                   |                                  | STREET ADDRESS (If rural, give location)   |                                     |
| 3. NAME OF DECEASED<br>(Type or Print) <u>Edith</u> (First) <u>Shepherd</u> (Middle) <u>Welch</u> (Last) |                                  | 4. DATE OF DEATH<br>(Month) <u>10</u> (Day) <u>19</u> (Year) <u>1956</u>                                       |                                     |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>WIDOWED</u>   | 8. DATE OF BIRTH<br><u>10-14-70</u> |
| 9. AGE last birthday<br><u>86</u> yrs.   |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u> |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><u>LOTHIAN, MD.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                                     |
| 13. FATHER'S NAME<br><u>EMER SHEPHERD</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>KATE HILDT</u>  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) |                                  | 16. SOCIAL SECURITY No. <u>1</u>   |                                     |
| 17. INFORMANT AND ADDRESS<br><u>MCLAN Welch, Annapolis, MD.</u>  |                                  |  |                                     |

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Hypertensive Cardio-Vascular Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 da.

10-7-56

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

|   |  |   |  |                       |          |         |
|---|--|---|--|-----------------------|----------|---------|
| 21. ACCIDENT (Specify)<br>SUICIDE<br>HOMICIDE |  | PLACE (Home, farm, factory, street, OF office bldg., etc.)<br>INJURY                              |  | (CITY OR TOWN)        | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY    |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  | HOW DID INJURY OCCUR? |          |         |

22. I hereby certify that I attended the deceased from 5/20, 1952, to 10-19, 1956, that I last saw the deceased

alive on 10-18, 1956, and that death occurred at 6:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

|  |  |   |  |  |                      |
|--|--|---|--|--|----------------------|
| 23. BURIAL, CREMATION REMOVAL (Specify)<br><u>BURIAL</u> |  | DATE THEREOF<br><u>10/21/56</u>               | NAME OF CEMETERY OR CREMATORY<br><u>MT. ZION</u> | LOCATION (City, town, or county)<br><u>LOTHIAN MD</u>            | (State)<br><u>MD</u> |
| DATE REC'D BY LOCAL REG.<br><u>10/29/56</u>              |  | REGISTRAR'S SIGNATURE<br><u>J.E. Haggerty</u> |  | 24. FUNERAL DIRECTOR<br><u>B.L. Hopping &amp; Son, Annapolis</u> |                      |

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A

BUREAU V. S.

OCT 2 1900

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

101112

10126

|  |                                      |  |  |
|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>   |                                      | c. LENGTH OF STAY IN 1b  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brick Walk Stone Chapel La.</u>  |                                      | d. STREET ADDRESS <u>Brick Walk Stone Chapel La</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>ELIZABETH WHARTON</u>   |                                      | 4. DATE OF DEATH <u>Oct 19</u> 1956  |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>            | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 19 1877</u>                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Phila Pa</u>  |                                      | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>George W Wharton</u>  |                                      | 14. MOTHER'S MAIDEN NAME <u>Josephine Page</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)   |                                      | 16. SOCIAL SECURITY NO. <u>-</u>   |  |
| 17. INFORMANT <u>Edm. A Howard</u>   |                                      | - Address <u>Pikesville md</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal disease</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arterio sclerosis</u><br>DUE TO (c) <u>Hypertension</u> |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><u>15 yrs.</u><br><u>15 yrs.</u><br><u>25 yrs.</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                      | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. 19   |                                      | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>May</u> 19 <u>37</u> to <u>Oct 19</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 19</u> 19 <u>56</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.  |                                      | ADDRESS (Street, city or town, state) <u>Pikesville 8, Md</u>  |  |
| ACTUAL SIGNATURE <u>Palmer FC Williams</u> M.D.  |                                      | DATE SIGNED <u>Oct 21 56</u>   |  |
| PHYSICIAN'S NAME (Type)  |                                      |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>   | 22b. DATE THEREOF <u>Oct 22 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>  | 22d. LOCATION (City, town, or county) (State) <u>Philadelphia Pa</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Williams &amp; Sons Co</u>   |                                      | ADDRESS <u>4905 York Rd</u>  |  |
| 24. REC'D BY REGISTRAR <u>Donna H. Hovell</u>  |                                      | DATE   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 23 1956

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar for burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10112

10127

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>o COUNTY <b>BALTIMORE</b> MARYLAND   |  |  |  | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o STATE <b>MARYLAND</b> b COUNTY <b>BALTIMORE</b>                   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CATONSVILLE</b>  |  |  |  | c. LENGTH OF STAY IN lb<br><b>8MONTHS</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>SPRING G ROVE STATE HOSPITAL</b>  |  |  |  | d. STREET ADDRESS <b>1904 Alson Drive</b><br><b>2817 BRIGHTON STREET</b>  |  |   |  |
| e. IS RESIDENCE ON A FARM<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>GEORGE</b> Middle <b>W</b> Last <b>WHITESIDE</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>OCTOBER 12</b> , Day <b>12</b> , Year <b>1956</b>  |  |   |  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>         |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>FEB. 23, 1866</b>  |  |
| 9. AGE (In years last birthday)<br><b>90</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MINISTER (rtd)</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>BAPTIST CHURCH</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>JOHN WHITESIDE</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>ELIZA MAHOOD</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><b>UNKNOWN</b>  |  |  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Address<br><b>CHART SPRING GROVE STATE HOSPITAL</b>                |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br>DUE TO <b>Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b><br>DUE TO (c) |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>years</b><br><b>years</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)              |  |
| 20f. (City or town)   |  |  |  | (County)  |  | (State)   |  |
| 21. I certify that I attended the deceased from <b>FEB. 9</b> , 19 <b>56</b> , to <b>OCT. 14</b> , 19 <b>56</b> that I last saw the deceased alive on <b>OCT. 14</b> , 19 <b>56</b> , and that death occurred at <b>12.00 M.</b> from the causes and on the date stated above.  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Charles Ward</b> M.D.   |  |  |  | ADDRESS (Street, city or town, state)   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Charles Ward M.D.</b>  |  |  |  | DATE SIGNED <b>10/15/56</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>10/17/56</b>     |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Louder Park Cem.</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b>                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Tidener &amp; Sons</b>  |  |  |  | ADDRESS<br><b>Balto 17 Md</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE   |  |
| 24b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |   |  |

BUREAU N. S.

OCT 15 1956

RECEIVED



10128

CERTIFICATE OF DEATH

10113

Reg. Dist. No.

30

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u><br>c. LENGTH OF STAY IN b. <u>28</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove Hospital</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>Anne Arundel</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastport</u><br>d. STREET ADDRESS <u>701 Chesapeake Ave</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>DANIEL</u> Middle <u>THOMAS</u> Last <u>WIGGINS</u>  |  | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>27</u> Year <u>1956</u>  |   |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>Oct 8 1872</u>                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Naval officer</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>US NAVY RET.</u>   | 9. AGE (In years, months, days, hours, minutes) <u>84</u> yrs.    |
| 11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |   |
| 13. FATHER'S NAME <u>Unknown</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1900-1919</u>  |  | 16. SOCIAL SECURITY NO. <u>Isabelle B. Wiggins</u>  |   |
| 17. INFORMANT <u>Isabelle B. Wiggins</u>   |  | Address <u>Meltington Tenn.</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u><br>DUE TO <u>12201</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>12201</u> DUE TO (c) <u>12201</u> |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12201</u>   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>0</u> M. <u>11</u> P. M. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                              |
| 21. I certify that I attended the deceased from <u>12/13</u> , 19 <u>54</u> , to <u>10/27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/26</u> , 19 <u>56</u> , and that death occurred at <u>7:05 A.M.</u> , from the causes and on the date stated above.   |  |   |   |
| ACTUAL SIGNATURE <u>Rena Becker</u>  |  | ADDRESS (Street, city or town, state) <u>Spring Grove Hospital Catonsville Md</u>   |   |
| PHYSICIAN'S NAME (Type) <u>John W. Taylor</u>  |  | DATE SIGNED <u>10/27/56</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct. 31-1956</u>  | 22b. DATE THEREOF <u>Oct. 31-1956</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy</u>   | 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor</u>   |  | 24. REC'D BY REGISTRAR <u>10/29/56</u>  |   |

BUREAU V. S.

OCT 1956

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10129

CERTIFICATE OF DEATH

10114

Reg. Dist. No. 33

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Baltimore</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Owings Mills, Md.</u><br>c. LENGTH OF STAY IN 1b<br><u>2 1/2 mos.</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Rosewood State Training School</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><u>Maryland</u><br>b. COUNTY<br><u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Waldorf</u><br>d. STREET ADDRESS<br><u>Route #1 - Box 111</u><br>• IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>James Edward Williams</u>   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>10 10 1956</u>   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>5/15/39</u>   |
| 9. AGE (In years last birthday)<br><u>17</u> yrs.  |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>patient in hospital</u>  | 11. BIRTHPLACE (State or foreign country)<br><u>West Virginia</u>                |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   | 13. FATHER'S NAME<br><u>Carl L. Williams</u>  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Melda Ruth Mannis</u>   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>  |  |
| 16. SOCIAL SECURITY NO.<br><u>-----</u>  |   | 17. INFORMANT<br><u>Rosewood Records</u> Address<br><u>Owings Mills, Md.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxiation (inspired multiple food particles in bronchus).</u><br>DUE TO (b) <u>Epilepsy - grand mal type</u><br>DUE TO (c) <u>-----</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>Since 2 yrs. of age.</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>-----</u>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>-----</u>  | 20f. (City or town) (County) (State)<br><u>-----</u>                             |
| 21. I certify that I attended the deceased from <u>July 16, 1956</u> , to <u>October 10, 1956</u> , that I last saw the deceased alive on <u>October 10, 1956</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Owings Mills, Maryland</u><br>DATE SIGNED <u>10/11/56</u>   |   |   |  |
| ACTUAL SIGNATURE <u>Harry G. Butler</u><br>PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>  |   | ADDRESS <u>Owings Mills, Maryland</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 22b. DATE THEREOF<br><u>10-15-56</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>PARKLAWN CEM</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>ROCKVILLE, MD</u>            |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert C. Humphrey</u>  |   | ADDRESS<br><u>Bethesda, Md</u>  | 24a. REC'D BY REGISTRAR<br><u>DATE 10-16-56</u>                                  |
|  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Mary B. Elina</u>  |  |

U. S. A. OVER

OFFICE

9980

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

|  |                              |  |  |  |   |   |  |
|--|------------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |                              |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>DUNDALK - 22</b>  |                              |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>DUNDALK</b>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1912 QUEENSWAY</b>  |                              |  |  | d. STREET ADDRESS<br><b>1912 QUEENSWAY</b>   |   |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |  |  |  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>LOUISA</b> First Middle Last <b>WILSON</b>   |                              | 4. DATE OF DEATH<br>Month <b>OCT</b> Day <b>25</b> Year <b>1956</b>  |  |  |   |   |  |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>DEC. 18, 1869</b> | 9. AGE (In years last birthday)<br><b>86</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                              | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>REMER JACOB REMERS</b>   |                              |  |  | 14. MOTHER'S MAIDEN NAME<br><b>LOUISE GERMRAUTH</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                              | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>ROSALIE McNALLY</b> Address <b>1912 QUEENSWAY</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Accident</b><br><b>4.00</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-Sclerotic Cardiovascular Disease</b><br>DUE TO <b>Serum</b><br>(c) <b>Serum</b> |                              |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 HRS</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>   |  |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>                                     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Nov. 4, 1956</b> to <b>Oct 25, 1956</b> , that I last saw the deceased alive on <b>Oct 24, 1956</b> , and that death occurred at <b>11:05 A.M.</b> from the causes and on the date stated above.  |                              |  |  |  |   |   |  |
| ACTUAL SIGNATURE<br><b>M.B. Davis</b>  |                              | M.D. <b>6800 McEwing + m Row - 10/26/56</b>  |  | ADDRESS (Street, city or town, state)<br><b>Dundalk - 22 - Md</b>  |   | DATE SIGNED<br><b>10/26/56</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>M.B. DAVIS M.D.</b>  |                              |  |  |  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                              | 22b. DATE THEREOF<br><b>OCT. 29, 1956</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>BALTO. CITY MD.</b>                           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Weber</b> ADDRESS <b>401 S. Chester St.</b>   |                              |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>10/26/56</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Wm. M. Kelly</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or

TO REGISTRAR: This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10130** 0,12 **CERTIFICATE OF DEATH**

**10116**

Reg. Dist. No.

|  |                               |   |   |  |  |  |  |
|--|-------------------------------|---|---|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                               |   |   | 2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EAST POINT</u>   |                               |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EAST POINT</u>                         |  |  |  |
| c. LENGTH OF STAY IN 1b <u>3 1/2 years</u>   |                               |   |   | d. STREET ADDRESS <u>7410 Belmont ave</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7410 Belmont ave</u>   |                               |   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Maryanna</u>  |                               | First Middle Last <u>Wisniewski</u>   |   | 4. DATE OF DEATH <u>October 12</u>   |  | Year <u>1956</u>   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH <u>Feb. 2 1881</u>             | 9. AGE (In years last birthday) <u>71</u> yrs.   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS        |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handwife</u>  |                               |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u> |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |  |  |
| 13. FATHER'S NAME <u>Michael Bakserak</u>  |                               |   |   | 14. MOTHER'S MAIDEN NAME <u>unknown</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>219-03-1818</u>  |   | 17. INFORMANT <u>Floyd Wisniewski</u> Address <u>7410 Belmont ave</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |                               |   |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>  |                               |   |   |  |  |  | <u>5 months</u>  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |                               |   |   |  |  |  | <u>6 years</u>   |
| DUE TO <u>Diabetes Mellitus</u>  |                               |   |   |  |  |  | <u>4 years</u>   |
| DUE TO <u>Hypertension</u>   |                               |   |   |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |   |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                               |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <u>19</u>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>June</u> 1955, to <u>Oct 12</u> 1956, that I last saw the deceased alive on <u>Oct 12</u> 1956, and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above. |                               |   |   |  |  |  |  |
| ACTUAL SIGNATURE <u>Morris A. Jacobs</u>   |                               |   |   | ADDRESS (Street, city or town, state) <u>1010 North Point Rd Baltimore Md</u>  |  |  |  |
| DATE SIGNED <u>10/13/56</u>  |                               |   |   |  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>MORRIS A. Jacobs</u>  |                               |   |   | Baltimore Md   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                               | 22b. DATE THEREOF <u>OCT 16, 1956</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEM</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>GERMAN HILL RD. DUNDALK</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Weber</u>  |                               |   |   | ADDRESS <u>4415 Chester St</u>   |  | 24a. REC'D BY REGISTRAR DATE   |  |
|  |                               |   |   |  |  | 24b. REGISTRAR'S SIGNATURE   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 15 1956

BUREAU



The

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

10131

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

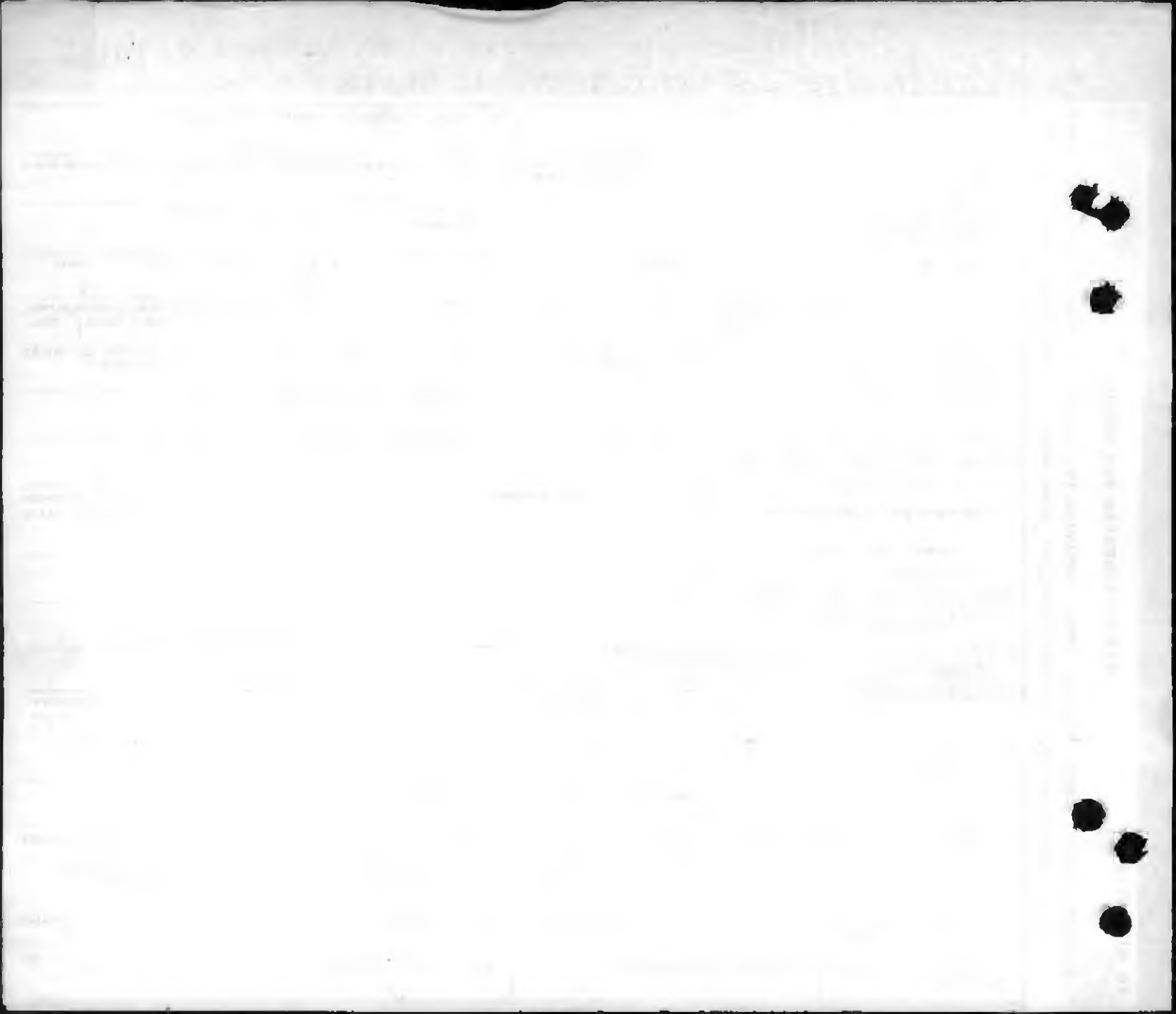
10117

## Baltimore Co. CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                |  |  |  |   |
|--|--------------------------------|--|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <u>WASHINGTON WORRELL WOOLSON Jr.</u>   |                                |  | 2. DATE OF DEATH <u>10/11/56</u>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <u>Baltimore County</u>  |                                |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> |  |   |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br><u>AT HOME</u>   |                                |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>BALTIMORE 45</u>                                    |  |   |
| c. Length of stay in Baltimore <u>25 yrs</u>   |                                |  | D. STREET ADDRESS (If rural, give location)<br><u>1811 ABERDEEN RD</u>   |  |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>CAU</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>married</u>                                      | 8. DATE OF BIRTH<br><u>FEB 28 1885</u>   |  | 9. AGE (In years last birthday) <u>71</u>                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>INSURANCE</u>  |                                |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>-</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>PHILADELPHIA, PA.</u> |
| 13. FATHER'S NAME<br><u>WASHINGTON WORRELL WOOLSON Sr.</u>   |                                |  | 14. MOTHER'S MAIDEN NAME<br><u>MARY BETTS</u>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown)<br><u>No</u>   |                                |  | 16. SOCIAL SECURITY NO.<br><u>-</u>  |  | 17. INFORMANT<br><u>WIFE</u>  |
| 18. <u>420.0</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>ARTERIOSCLEROTIC HEART DISEASE - CONGESTIVE HEART FAILURE</u>                       |                                |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4-5 yrs</u>   |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><u>GENERALIZED ARTERIOSCLEROSIS</u>  |                                |  |  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                |  |  |  |   |
| IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |                                | 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                 |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                       |   |
| 22. I certify that (I) (this hospital) attended the deceased from <u>OCT 1</u> 19 <u>56</u> to <u>OCT 11</u> 19 <u>56</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>OCT 10</u> 19 <u>56</u> , and that death occurred at <u>2:00A</u> m., from the causes and on the date stated above. |                                |  |  |  |   |
| 23A. SIGNATURE<br><u>Donald W. Mintz</u>   |                                | 23B. ADDRESS<br><u>3009 EVERGREEN AVE</u>  |  | 23C. DATE SIGNED<br><u>10/11/56</u>                              |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                | 24B. DATE<br><u>10/15/56</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Glenwood Mem garden</u> |   |
| 24D. LOCATION (City, town, or county) (State)<br><u>Phila - Penna</u>  |                                | 25. FUNERAL DIRECTOR<br><u>Lemond L Ruck</u>   |  | ADDRESS<br><u>5305 Hartford</u>                                  |   |

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10118 30  
Reg. Dist. No.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b><br>c. LENGTH OF STAY IN 1b <b>6310</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Catonsville</b><br><b>6310 Frederick Ave.</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY <b>Balto.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b><br>d. STREET ADDRESS <b>6310 Frederick Ave</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>John Oliver Zimmerman</b>   |  |  |  | 4. DATE OF DEATH Month Day Year<br><b>October 31 1956</b>   |  |   |  |
| 5. SEX <b>male</b>  |  | 6. COLOR OR RACE <b>white</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>Aug. 29, 1891</b>                           |  |
| 9. AGE (In years and months) <b>65 yrs.</b>   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Route Man</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>MD</b>             |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 13. FATHER'S NAME <b>Joseph Zimmerman</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Sophie (unknown)</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  | 16. SOCIAL SECURITY NO. <b>213-10-1200</b>   |  | 17. INFORMANT Address <b>Mrs. Gertrude M. Zimmerman. 6310 Frederick Ave</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. DUE TO (c)   |  |  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                            |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Geo. S. M. Kieffer</b><br>EXAMINER'S NAME (Type) <b>Geo. S. M. Kieffer M.D.</b>   |  |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| DATE SIGNED <b>Oct. 31, 56</b>  |  |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>11-3-56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Western Cem</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Schenck &amp; Sons</b>   |  |  |  | 24a. REC'D BY REGISTRAR <b>DATE Nov. 5, 1956</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>F. E. Henry</b>                   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar for burial, cremation, or removal.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
NOV 7 1956  
BUREAU V. S.